Chapter 1: Getting started as a member

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If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
A. Welcome to Blue Cross Community MMAI

Blue Cross Community MMAI is a Medicare-Medicaid Plan. A Medicare-Medicaid plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care coordinators and care teams to help you manage all your providers and services. They all work together to provide the care you need.

Blue Cross Community MMAI was approved by the State of Illinois and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the Medicare-Medicaid Alignment Initiative. The Medicare-Medicaid Alignment Initiative is a demonstration program jointly run by the State of Illinois and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you receive your Medicare and Medicaid health care services.

B. What are Medicare and Medicaid?

Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, and
- people with end-stage renal disease (kidney failure)

Medicaid

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides what counts as income and resources and who qualifies. They also decide what services are covered and the cost for services. States can decide how to run their programs, as long as they follow the federal rules.

Medicare and Illinois must approve Blue Cross Community MMAI each year. You can get Medicare and Medicaid services through our plan as long as:

- we choose to offer the plan, and
- Medicare and the State approve the plan

Even if our plan stops operating in the future, your eligibility for Medicare and Medicaid services will not be affected.

C. What are the advantages of this plan?

You will now get all your covered Medicare and Medicaid services from Blue Cross Community MMAI, including prescription drugs. You do not pay extra to join this health plan.

Blue Cross Community MMAI will help make your Medicare and Medicaid benefits work better together, and work better for you. Some of the advantages include:

- You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a care coordinator. This is a person who works with you, with Blue Cross Community MMAI, and with your care providers to make sure you get the care you need.
- You will be able to direct your own care with help from your care team and care coordinator.
- The care team and care coordinator will work with you to come up with a care plan specifically designed to meet your health needs. The care team will be in charge of coordinating the services you need. This means, for example:
  - Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
  - Your care team will make sure your test results are shared with all your doctors and other providers.
D. What is Blue Cross Community MMAI’s service area?

Our service area includes these counties in Illinois: Cook, DuPage, Kane, Kankakee, Lake and Will counties.

Only people who live in our service area can get Blue Cross Community MMAI.

If you move outside of our service area, you cannot stay in this plan.

E. What makes you eligible to be a plan member?

You are eligible for our plan as long as:

• you live in our service area, and

• you have both Medicare Part A and Medicare Part B, and

• you are eligible for Medicaid, and

• you are age 21 and older at the time of enrollment, and

• you are enrolled in the Medicaid Aid to the Aged, Blind and Disabled category of assistance, and

• if you meet all other Demonstration criteria and are in the following Medicaid 1915(c) waivers:
  – Persons who are Elderly
  – Persons with Disabilities
  – Persons with HIV/AIDS
  – Persons with Brain Injury, or
  – Persons residing in Supportive Living Facilities

• 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.

F. What to expect when you first join a health plan

When you first join the plan, you will receive a health risk assessment within the first 90 days.

The Health Risk Assessment (HRA) is completed annually with a health expert from the plan. It is done in person or on the phone. During the HRA, the interviewer will:

• Review your personal information
• Tell you how to find a PCP or specialist
• Tell you how to contact your Care Coordinator
• Let you know if you will have a home- or long-term care facility visit
• Give you a more detailed health assessment if needed

If this is your first time in a Medicare-Medicaid Plan, you can keep seeing the doctors you go to now for 180 days. If you changed to Blue Cross Community MMAI from a different Medicare-Medicaid Plan, you can keep seeing the doctors you go to now for 90 days.

After the first 180 days, you will need to see doctors and other providers in the Blue Cross Community MMAI network. A network provider is a provider who works with the health plan. See Chapter 3 Section D, page 23 for more information on getting care.

G. What is a care plan?

A care plan is the plan for what medical, behavioral, long term supports, social and functional services you will get and how you will get them.

After your health risk assessment, your care team will meet with you to talk about what services you need and want. Together, you and your care team will make a care plan.

Every year, your care team will work with you to update your care plan when the services you need and want change.

If you are receiving Home and Community Based Waiver services, you will also have a service plan. The service plan lists the services you will get and how often you will get them. This service plan will become part of your overall care plan.
H. Does Blue Cross Community MMAI have a monthly plan premium?

No.

I. About the Member Handbook

This Member Handbook is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, Section 4, page 93, or call 1-800-MEDICARE (1-800-633-4227).

The contract is in effect for the months you are enrolled in Blue Cross Community MMAI between January 1, 2015 and December 31, 2015.

J. What other information will you get from us?

You should have already gotten a Blue Cross Community MMAI member ID card, information about how to access a Provider and Pharmacy Directory, and a List of Covered Drugs.

Your Blue Cross Community MMAI member ID card

Under our plan, you will have one card for your Medicare and Medicaid services, including long-term services and supports, and prescriptions. You must show this card when you get any services or prescriptions. Here’s a sample card to show you what yours will look like:

If your card is damaged, lost or stolen, call Member Services right away and we will send you a new card. As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Medicaid card to get services. Keep those cards in a safe place, in case you need them later.
Provider and Pharmacy Directory

The Provider and Pharmacy Directory lists the providers and pharmacies in the Blue Cross Community MMAI network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (see page 22).

You can request an annual Provider and Pharmacy Directory by calling Member Services at 1-877-723-7702 (TTY/TDD 711). We are open:

October 1 to February 14
8 a.m. to 8 p.m., Central time
Seven days a week

February 15 to September 30
8 a.m. to 8 p.m., Central time
Monday through Friday

Alternate technologies (for example, voicemail) will be used on the weekends and holidays. The call is free.

You can also see the Provider and Pharmacy Directory at www.bcbsilcommunitymmai.com, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

What are “network providers”?

• Network providers are doctors, nurses, and other health care professionals that you can go to as a member of our plan. Network providers also include clinics, hospitals, nursing facilities, and other places that provide health services in our plan. They also include home health agencies, medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid. Long-term support and services are also included, such as:

  – home services
  – day habilitation services
  – home health care or personal care attendant services
  – adult day health services
  – nursing home care
  – respite care and home modifications

• Network providers have agreed to accept payment from our plan for covered services as payment in full.

What are “network pharmacies”?

• Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the Provider and Pharmacy Directory to find the network pharmacy you want to use.

• Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Services at 1-877-723-7702 (TTY/TDD 711) for more information or to get a copy of the Provider and Pharmacy Directory. We are open:

October 1 to February 14
8 a.m. to 8 p.m., Central time
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Monday through Friday

You can also see the Provider and Pharmacy Directory at www.bcbsilcommunitymmai.com, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network pharmacies and providers.

List of Covered Drugs

The plan has a List of Covered Drugs. We call it the Drug List for short. It tells which prescription drugs are covered by Blue Cross Community MMAI.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. See Chapter 5, Section C, page 65 for more information on these rules and restrictions.

Each year, we will send you a copy of the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit www.bcbsilcommunitymmai.com or call 1-877-723-7702 (TTY/TDD 711). We are open:

October 1 to February 14
8 a.m. to 8 p.m., Central time
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Blue Cross Community MMAI Member Handbook

The Explanation of Benefits

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or *EOB*).

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 5 gives more information about the *Explanation of Benefits*, and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services.

K. How can you keep your Enrollee Profile up to date?

You can keep your enrollee profile up to date by letting us know when your information changes. The plan’s network providers and pharmacies need to have the right information about you. They use your enrollee profile to know what services and drugs you get and how much it will cost you. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- If you have any changes to your name, your address, or your phone number
- If you have any changes in any other health insurance coverage, such as from your employer, your spouse’s employer, or workers’ compensation
- If you have any liability claims, such as claims from an automobile accident
- If you are admitted to a nursing home or hospital
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your caregiver or anyone responsible for you changes
- If you are part of a clinical research study

If any information changes, please let us know by calling Member Services at **1-877-723-7702** (TTY/TDD **711**). We are open:

- **October 1 to February 14**
  - 8 a.m. to 8 p.m., Central time
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  - 8 a.m. to 8 p.m., Central time
  - Monday through Friday

Do we keep your personal health information private?

Yes. Laws require that we keep your medical records and personal health information private. We make sure that your health information is protected. For more information about how we protect your personal health information, see the *HIPAA Notice of Privacy Practices* located on [www.bcbsilcommunitymmai.com](http://www.bcbsilcommunitymmai.com).
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If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymm.ai.com.
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| FAX      | 1-855-674-9193 |
| WRITE    | P.O. Box 3836 Scranton, PA 18505 |
| WEBSITE  | www.bcbsilcommunitymmai.com |
Contact Member Services about:

Questions about the plan

Questions about claims, billing or member cards

Coverage decisions about your health care
A coverage decision about your health care is a decision about:

- your benefits and covered services, or
- the amount we will pay for your health services.

Call us if you have questions about a health care coverage decision.

› To learn more about coverage decisions, see Chapter 9, Section 4, page 93.

 Appeals about your health care
- An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.

› To learn more about making an appeal, see Chapter 9, Section 4, page 93.

Complaints about your health care
You can make a complaint about us or any provider – including a non-network or network provider. A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (see Section F below).

If your complaint is about a coverage decision about your health care, you can make an appeal. (See the section above.)

You can send a complaint about Blue Cross Community MMAI right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

› For more on making a complaint about your health care, see Chapter 9, Section 10, page 172.

Coverage decisions about your drugs
A coverage decision about your drugs is a decision about:

- your benefits and covered drugs, or
- the amount we will pay for your drugs.

This applies to your Part D drugs, Medicaid prescription drugs, and Medicaid over-the-counter drugs.

› For more on coverage decisions about your prescription drugs, see Chapter 9, Section 6, page 102.

 Appeals about your drugs
An appeal is a way to ask us to change a coverage decision.

› For more on making an appeal about your prescription drugs, see Chapter 9, Section 6.5, page 106 or call Member Services at 1-877-723-7702 (TTY/TDD 711).

Complaints about your drugs
You can make a complaint about us or a pharmacy. This includes a complaint about your prescription drugs.

If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (See the section above.)

You can send a complaint about Blue Cross Community MMAI right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

› For more on making a complaint about your prescription drugs, see Chapter 9, Section 10, page 172.

Payment for health care or drugs you already paid for

› For more on how to ask us to pay you back, or to pay a bill you have gotten, see Chapter 7, Section B, page 77.

› If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. See Chapter 9, Section 5.5, page 101 for more on appeals.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
### B. How to contact your Care Coordinator

As a member of Blue Cross Community MMAI, you will be assigned a Care Coordinator. Your Care Coordinator will help you manage all your doctors and health services. He or she will make sure you get all the tests, labs and other care you need. They also make sure that your test results are shared with your health care team. To reach your Care Coordinator, or for questions about changing your Care Coordinator:

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Contact your Care Coordinator about:

Questions about your health care

Questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)

If your provider or Care Coordinator thinks you may be eligible for long-term care or additional supports and services to keep you in your home, you will be referred to an agency that will decide if you are eligible for those services.

Sometimes you can get help with your daily health care and living needs. You might be able to get these services:

- Adult Day Care
- Travel to Adult Day Care
- Behavioral Services
- Day Habilitation to help regain independence in your home
- Emergency Home Response System (devices that call for help by pushing a button)
- Home Accessibility Improvements like wheelchair ramps or bathroom railings
- Home Delivered Meals
- Home health care
- Homemaker
- Intermittent Nursing
- Occupational therapy
- Personal Aide
- Physical therapy
- Prevocational Services
- Skilled Nursing Care
- Specialized Medical Equipment and Supplies
- Speech therapy
- Supported Employment
- Respite for family and friend caregiver
## C. How to contact the Nurse Advice Call Line

Our free 24/7 Nurse Advice Call Line will connect you with a nurse who can answer your health questions. The nurse can help you decide if you need to go to the ER or urgent care center, or if you should wait to see your PCP. If you think you have an urgent problem and your doctor cannot see you right away, call the Nurse Advice Call Line for help.

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<th>CALL</th>
<th>1-888-343-2697</th>
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Contact the Nurse Advice Call Line about:

- Questions about your health care

## D. How to contact the Behavioral Health Crisis Line

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Contact the Behavioral Health Crisis Line about:

- Feelings of hurting yourself or others
- Wanting to give up
- Feeling confused or upset
- Feeling out of control

If you are experiencing a medical emergency, please call 911.
E. How to contact the Senior Health Insurance Program (SHIP)

The Senior Health Insurance Program (SHIP) gives free health insurance counseling to people with Medicare. SHIP is not connected with any insurance company or health plan.

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<th>CALL</th>
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<td>TTY/TDD</td>
<td>1-866-323-5321</td>
</tr>
</tbody>
</table>
| WRITE              | Senior Health Insurance Program  
                     Illinois Department on Aging  
                     One Natural Resources Way, Suite 100  
                     Springfield, IL 62702-1271 |
| EMAIL              | aging.ship@illinois.gov |
| WEBSITE            | www.state.il.us/aging/ship |

Contact SHIP about:

Questions about your Medicare health insurance

SHIP counselors can:

- help you understand your rights,
- help you understand your plan choices,
- answer your questions about changing to a new plan,
- help you make complaints about your health care or treatment, and
- help you straighten out problems with your bills.
F. How to contact the Quality Improvement Organization (QIO)

Our state has an organization called Telligen QIO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Telligen QIO is not connected with our plan.

<table>
<thead>
<tr>
<th>CALL</th>
<th>1-800-647-8089</th>
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<tr>
<td>TTY/TDD</td>
<td>711</td>
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<tr>
<td></td>
<td>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</td>
</tr>
<tr>
<td>WRITE</td>
<td>Telligen</td>
</tr>
<tr>
<td></td>
<td>Attn: BFCC</td>
</tr>
<tr>
<td></td>
<td>1776 West Lakes Parkway</td>
</tr>
<tr>
<td></td>
<td>West Des Moines, IA  50266</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.telligenqio.org">www.telligenqio.org</a></td>
</tr>
</tbody>
</table>

Contact Telligen QIO about:

Questions about your health care

You can make a complaint about the care you have received if:

- You have a problem with the quality of care,
- You think your hospital stay is ending too soon, or
- You think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.
G. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

<table>
<thead>
<tr>
<th>CALL</th>
<th>1-800-MEDICARE (1-800-633-4227)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Calls to this number are free, 24 hours a day, seven (7) days a week.</td>
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<tr>
<th>TTY/TDD</th>
<th>1-877-486-2048</th>
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<tr>
<td></td>
<td>This call is free.</td>
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<tr>
<td></td>
<td>This number is for people who have hearing or speaking problems.</td>
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<tr>
<td></td>
<td>You must have special telephone equipment to call it.</td>
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</table>

<table>
<thead>
<tr>
<th>WEBSITE</th>
<th><a href="http://www.medicare.gov">www.medicare.gov</a></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting “Help &amp; Resources” and then clicking on “Phone numbers &amp; websites.”</td>
</tr>
<tr>
<td></td>
<td>The Medicare website has the following tool to help you find plans in your area:</td>
</tr>
<tr>
<td></td>
<td><strong>Medicare Plan Finder:</strong> Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Find health &amp; drug plans.”</td>
</tr>
<tr>
<td></td>
<td>If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.</td>
</tr>
</tbody>
</table>
H. How to contact Medicaid

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about your Medicaid eligibility, call the Illinois Department of Human Services help line.

<table>
<thead>
<tr>
<th>CALL</th>
<th>1-800-843-6154</th>
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</thead>
<tbody>
<tr>
<td>TTY/TDD</td>
<td>1-800-447-6404</td>
</tr>
<tr>
<td>EMAIL</td>
<td><a href="mailto:dhs.webbits@illinois.gov">dhs.webbits@illinois.gov</a></td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.dhs.state.il.us">www.dhs.state.il.us</a></td>
</tr>
</tbody>
</table>

I. How to contact the Illinois Health Benefits Hotline

The Illinois Health Benefits Hotline helps people enrolled in Medicaid with service or billing problems. They can help you file a complaint or an appeal with our plan.

<table>
<thead>
<tr>
<th>CALL</th>
<th>1-800-226-0768</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTY/TDD</td>
<td>1-877-204-1012</td>
</tr>
</tbody>
</table>
| WEBSITE        | www2.illinois.gov/hfs  
This is the official website for Medicaid. It gives you up-to-date information about Medicaid. |
J. How to contact the Illinois Long Term Care Ombudsman Program

The Illinois Long Term Care Ombudsman Program helps protect and promote the rights of people who live in nursing homes and other long-term care settings. It also helps solve problems between these settings and residents or their families.

<table>
<thead>
<tr>
<th>CALL</th>
<th>1-800-252-8966</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTY/TDD</td>
<td>1-888-206-1327</td>
</tr>
</tbody>
</table>
| WRITE         | Long Term Care Ombudsman Program  
Illinois Department on Aging  
One Natural Resources Way, Suite 100  
Springfield, IL 62702-1271 |
| EMAIL         | aging.ilsenior@illinois.gov |
| WEBSITE       | www.state.il.us/aging/1abuselegal/ombuds.htm |
Chapter 3: Using the plan’s coverage for your health care and other covered services

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If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
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   What should you do if you have a medical emergency? .............. 28
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A. About “services,” “covered services,” “providers,” and “network providers”

**Services** are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4, Section D, page 35.

**Providers** are doctors, nurses, specialists and other people who give you services and care. The term *providers* also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

**Network providers** are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you see a network provider, you usually pay nothing for covered services.

B. Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan

Blue Cross Community MMAI covers all services covered by Medicare and Medicaid. This includes medical, behavioral health, long term services and supports, and prescription drugs.

Blue Cross Community MMAI will generally pay for the health care and services you get if you follow the plan rules. To be covered:

- The care you get must be a **plan benefit**. This means that it must be included in the plan’s Benefits Chart. (The chart is in Chapter 4 Section D, page 35 of this handbook).

- The care must be **medically necessary**. *Medically necessary* means you need services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules.

- You do not need a referral from a PCP to see a network specialist. You do need a referral from a PCP and a prior authorization if you are going out of network.

- You do not need a referral from your PCP for emergency care or urgently needed care, or to see a network woman’s health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, see page 24.

➢ To learn more about choosing a PCP, see page 24.

**Please note:** If this is your first time in a Medicare-Medicaid Plan, you may continue to see your current providers for the first 180 days with our plan, at no cost, if they are not a part of our network. If you changed to Blue Cross Community MMAI from a different Medicare-Medicaid Plan, you may continue to see your current providers for the first 90 days with our plan, at no cost, if they are not a part of our network. During the transition time, our care coordinator will contact you to help you find providers in our network. After that time, we will no longer cover your care if you continue to see out-of-network providers.

If you have questions, please call Blue Cross Community MMAI at **1-877-723-7702** (TTY/TDD **711**), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit **www.bcbsilcommunitymmai.com**.
• **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when we will cover care from a provider who does not work with our health plan.

  – The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what emergency or urgently needed care means, see page 28.

  – If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. A referral to an out-of-network provider from your PCP requires prior approval from BCBSIL. In this situation, we will cover the care as if you got it from a network provider. To learn about getting approval to see an out-of-network provider, see page 25.

  – The plan covers kidney dialysis services when you are outside the plan’s service area for a short time. You can get these services at a Medicare-certified dialysis facility.

  – When you first join the plan, you can continue seeing the providers you see now for 180 days.

  – You may also get Emergency care, Urgent Care and Ambulance services from providers not in our network.

C. **Your Care Coordinator**

Everyone on your health care team works together to make sure you get the health care you need. You have a Care Coordinator who directs your care and an Interdisciplinary Care Team that works closely with your main caregiver to make sure that needed social and behavioral health services are included in your care plan.

• **What is a Care Coordinator?** Your Care Coordinator is in charge of arranging your care – and helping you manage your health providers and services. He or she will:

  – make sure you get all the tests, labs and other care that you need

  – make sure that your test results are shared with your Care Team and the right providers

  – always get your permission before sharing medical information with other providers.

• **How can you contact your Care Coordinator?** You may call Member Services at 1-877-723-7702 (TTY: 711) during these hours:

  October 1 to February 14: 8 a.m. to 8 p.m., Central time, Seven days a week

  February 15 to September 30: 8 a.m. to 8 p.m., Central time, Monday through Friday

This call is free. We have free translation for people who do not speak English.

• **How can a member change his or her Care Coordinator?** Call Member Services at 1-877-723-7702 (TTY: 711) during the hours above. This call is free. Ask for a translator if you do not speak English.
D. Getting care from primary care providers, specialists, other network providers, and out-of-network providers

Getting care from a primary care provider
You must choose a primary care provider (PCP) to provide and manage your care.

What is a PCP, and what does the PCP do for you?
A PCP is a doctor who gives you routine health care. Your PCP:

– will keep your medical records and get to know your health needs over time
– will give you a referral if you need to see an out-of-network provider.
– has signed a special Medical Service agreement with Blue Cross Blue Shield of Illinois.

• What types of providers may act as a PCP?
Your PCP could be a doctor specializing in Internal Medicine, Family Practice or Geriatrics. If you are a woman, you may select a Woman’s Health Care Provider, such as a Gynecologist or Obstetrician/Gynecologist (OB/GYN), as your PCP.

• Explain the role of a PCP. Your PCP is the most important person to help you with your health care needs. This is who you will go to first when you are sick or need a checkup. You and your PCP should work as a team to take care of your health. You should be able to talk to your PCP about all of your health care needs.

• What is the role of a PCP in coordinating covered services? Your PCP is responsible for handling all of your health care needs. He or she will provide most of your care and will help you arrange the rest of the covered services you get as a member of the Blue Cross Community MMAI Plan.

• What is the role of a PCP in making decisions about or getting prior authorization? Certain services require prior authorization. This means you get approval in advance from your PCP. If your PCP finds that a referral is needed, he or she will handle the process. Generally, this is done within the network of providers where your PCP has a set referral arrangement. You may contact your PCP for a list of the referral network. Keep in mind that benefits will not be paid for services or supplies that are not listed as covered – even if they have been ordered by your PCP.

• Can a clinic be your primary care provider? Yes. A clinic is sometimes known as a Primary Care Medical Home. This is a health care setting that teams up with a patient, his or her personal doctor and, when suitable, the patient’s family. Patients get care when and where they need and want it in a manner that respects their culture and language.
How do you choose your PCP?

You can choose your PCP when you enroll in Blue Cross Community MMAI. If you want to see a certain specialist or go to a specific hospital, check first to be sure the PCP has a referral arrangement with that specialist or hospital.

To choose a PCP, go to the list of doctors in your Blue Cross Community MMAI 2015 Provider and Pharmacy Directory and:

• choose a doctor that you use now, or
• choose a doctor who has been supported by someone you trust, or
• choose a doctor whose offices are easy for you to get to.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it’s possible that your PCP might leave our plan’s network. We can help you find a new PCP.

To change your PCP, just call Member Services at 1-877-723-7702 (TTY/TDD: 711) during these hours:

October 1 to February 14
8 a.m. to 8 p.m., Central time
Seven days a week
February 15 to September 30
8 a.m. to 8 p.m., Central time
Monday through Friday

This call is free. We have free translation for people who do not speak English. We’ll let you know the date the change will happen and send you a new ID card showing the change.

• If you ask us to change your PCP anytime during the month, you may see your new PCP the first calendar day of the next month. For example: If you call on April 13, you may see your new PCP on or after May 1.

• Please get care from your current PCP until the change takes place.

If your PCP or another provider that you see often leaves our network, we will send you a letter at least 30 days before the PCP leaves to let you know.

To choose a new provider, look in the Provider and Pharmacy Directory, call Member Services or go to the online provider directory at www.bcbsilcommunitymmai.com.

Services you can get without first getting approval from your PCP

You can get services like the ones listed below without first getting approval from your PCP:

• Emergency services from network providers or out-of-network providers.

• Care from network providers.

• Urgently needed care from out-of-network providers when you can’t get to network providers (for example, when you are outside the plan’s service area).

• Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan’s service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)

• Flu shots, hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.

• Routine women’s health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.

• Additionally, if you are eligible to receive services from Indian health providers, you may see these providers without a referral.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
How to get care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- **Oncologists** care for patients with cancer.
- **Cardiologists** care for patients with heart problems.
- **Orthopedists** care for patients with bone, joint, or muscle problems.

**What is the role (if any) of the PCP in referring members to specialists and other providers?**

If your PCP thinks you need to see a specialist or other provider, he or she will refer you. Your PCP will usually refer you to a provider that he or she has worked with before. You may also go see a specialist that is in our network without a PCP referral. Keep in mind that services or supplies not listed as covered (see Chapter 4) will not be covered – even if they are ordered by your PCP.

**What is the process for getting prior authorization?** Your PCP will handle the prior authorization process. See the Benefits Chart in Chapter 4, Section D page 35 for information about which services require prior authorization.

What if a network provider leaves our plan?

A network provider you are using might leave our plan. If your provider leaves the plan’s network, but remains in the service area, we will allow a transition period of 90 days from date of notice if you have an ongoing course of treatment or are in your third trimester of pregnancy, including postpartum care.

If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care.

If you are under medical treatment with the provider who is no longer with the plan, or you need urgent help with choosing a physician, please call Member Services at **1-877-723-7702** (TTY/TDD: 711) during these hours:

October 1 to February 14
8 a.m. to 8 p.m., Central time
Seven days a week
February 15 to September 30
8 a.m. to 8 p.m., Central time
Monday through Friday

This call is free. We have free translation for people who do not speak English.

How to get care from out-of-network providers

If you choose to go to a doctor outside of our network, without a referral from your PCP, you must pay for these services yourself. Neither the plan nor Original Medicare will pay for these services except for emergency care.

The exceptions to this rule are when you need urgent or emergency care or dialysis and cannot get to a provider in the plan, like when you are away from home. You can also go outside the plan for other non-emergency services if Blue Cross Community MMAI gives you permission first.

Please note: If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid. We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid. If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

If you have questions, please call Blue Cross Community MMAI at **1-877-723-7702** (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit [www.bcbsilcommunitymmai.com](http://www.bcbsilcommunitymmai.com).
E. How to get long-term services and supports (LTSS)

Long-term services and supports (LTSS) are for people who need help to do everyday tasks. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital.

For more information about LTSS services, please see the *Long Term Services and Support (LTSS) Handbook*.

F. How to get behavioral health services

Behavioral health services support mental health and substance abuse treatment needs you may have. This can include emotional, social, educational, and recovery care, as well as more common psychiatric or medical care. This care may be given in a community setting, such as a day program, or in another place that’s easier for you, like your home.

Please see the Benefits Chart in Chapter 4, Section D page 35 for more information, as well as the list of what you will need to get pre-approval for covered behavioral health care.

How do you get behavioral health services?

You can talk about the many services available with your Care Coordinator and other members of your Care Team. The Care Coordinator will support you in finding help in the area and help you schedule appointments or screenings.

Your Care Team may also include health outreach workers (community health workers) or other mental health experts that will be working with your Care Coordinator to make sure that you have all the support you need to stay well while staying in the community.

Most outpatient mental health care does not call for pre-approval. But some do. Your Care Team will help you with any needed pre-approval.

If you need any help, please call Member Services at 1-877-723-7702 (TTY/TDD: 711)

October 1 to February 14
8 a.m. to 8 p.m., Central time
Seven days a week

February 15 to September 30
8 a.m. to 8 p.m., Central time
Monday through Friday

All members who request and need mental health support can get behavioral health services.

Please see the Benefits Chart in Chapter 4, Section D page 35 for more information on behavioral services and prior authorization requirements.
G. How to get self-directed care

Self-directed care gives consumers and/or their families the right to design service and support plans that reflect their wishes. As a Member of Blue Cross Community MMAI you may be able to self-direct some of your services.

For example, you and your Interdisciplinary Care Team may decide you need a Personal Assistant (PA). The Self-Directed Care Program lets you hire and manage your PA. This includes overseeing your PA’s duties and signing his or her time sheet.

You will have an active part in writing and revising your plan of care. Here’s how it works:

- You will receive a call for a health risk assessment
- You will then be given a Care Coordinator
- Based on your assessment, you and your Care Coordinator will design your care plan to meet your needs (such as a PA, meal delivery, equipment)

H. How to get transportation services

You may be able to get transportation to and from your doctors’ office or health care facility. Trips must be for medical reasons only.

What services are covered?
The plan offers rides when you have no other way to get to:

- A doctor’s visit
- A visit with other health care providers
- A dental visit
- A pharmacy after a provider visit

What’s not covered?
The plan does not cover rides:

- For non-medical reasons
- To see a provider who is more than 65 miles from where you live (without special approval)
- To see a provider who is outside of our network (without special approval)

If you need a ride to the doctor, please call Member Services at 1-877-723-7702 (TTY/TDD: 711) at least 24 hours before your appointment.

Call 911 if you need emergency transportation. You do not need prior approval in an emergency.
I. How to get covered services when you have a medical emergency or urgent need for care

Getting care when you have a medical emergency

What is a medical emergency?

A medical emergency is a medical condition recognizable by symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, you or any prudent layperson with an average knowledge of health and medicine could expect it to result in:

- placing the person’s health in serious risk; or
- serious harm to bodily functions; or
- serious dysfunction of any bodily organ or part; or
- in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:
  - There is not enough time to safely transfer the member to another hospital before delivery.
  - The transfer may pose a threat to the health or safety of the member or unborn child.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get help as fast as possible. Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.

- As soon as possible, make sure that our plan has been told about your emergency. We need to follow up on your emergency care. You or your care coordinator should call to tell us about your emergency care, usually within 48 hours.

- Please call Member Services at 1-877-723-7702 (TTY/TDD: 711).

  We are open:
  - 8:00 a.m. until 8:00 p.m. CST
  - October 1 through February 14, seven days a week
  - February 15 through September 30, Monday through Friday

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Chapter 3: Using the plan’s coverage for your health care and other covered services

What is covered if you have a medical emergency?

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4, Section D page 35.

Emergency care outside the U.S. and its territories is not covered, except when:

- The emergency arose in the U.S. and the foreign hospital is closer than the nearest U.S. hospital that can treat your health problem.
- You’re traveling through Canada by the most direct route between Alaska and some other state, when a medical emergency occurs and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.
- You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, whether or not it’s an emergency.

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over. After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will require a referral from your PCP in order to be covered by our plan. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

What if it wasn’t a medical emergency after all?

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care and have the doctor say it wasn’t really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care. However, after the doctor says it was not an emergency, we will cover your additional care only if:

- you go to a network provider, or
- the additional care you get is considered “urgently needed care” and you follow the rules for getting this care. (See the next section.)

Getting urgently needed care

What is urgently needed care?

Urgently needed care is care you get for a sudden illness, injury, or condition that isn’t an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Getting urgently needed care when you are in the plan’s service area

In most situations, we will cover urgently needed care only if:

- you get this care from a network provider, and
- you follow the other rules described in this chapter.

However, if you can’t get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

You may go to any urgent care center if you believe you need urgent care. If you are within the plan’s service area, call your PCP’s Medical Group at the number on your member ID card for help on how to get urgent care. If you don’t have an ID card, call Member Services at 1-877-723-7702 for help.

Getting urgently needed care when you are outside the plan’s service area

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

Our plan does not cover urgently needed care or any other care that you get outside the United States.
J. What if you are billed directly for the full cost of services covered by our plan?

If a provider sends you a bill instead of sending it to the plan, you can ask us to pay the bill.

You should not pay the bill yourself. If you do, the plan may not be able to pay you back.
If you have paid for your covered services or if you have gotten a bill for covered medical services, see Chapter 7, pages 76-77 to learn what to do.

What should you do if services are not covered by our plan?
Blue Cross Community MMAI covers all services:

• that are medically necessary, and
• that are listed in the plan’s Benefits Chart (see Chapter 4, Section D, page 35), and
• that you get by following plan rules.
• If you get services that aren’t covered by our plan, you must pay the full cost yourself.
If you want to know if we will pay for any medical service or care, you have the right to ask us. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9, Section 4, page 93 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan’s coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

K. How are your health care services covered when you are in a clinical research study?

What is a clinical research study?
A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.
If you volunteer for a clinical research study, we will pay any costs if Medicare approves the study. If you are part of a study that Medicare has not approved, you will have to pay any costs for being in the study.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

If you are in a Medicare-approved clinical research study, Medicare pays for most of the covered services you get. While you are in the study, you may stay enrolled in our plan. That way you continue to get care not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your primary care provider. The providers that give you care as part of the study do not need to be network providers.

You do need to tell us before you start participating in a clinical research study.
Here’s why:

• We can tell you if the clinical research study is Medicare-approved.
• We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan to be in a clinical research study, you or your Care Coordinator should contact Member Services.
When you are in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren’t in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

Medicare pays most of the cost of the covered services you get as part of the study. After Medicare pays its share of the cost for these services, our plan will also pay for the rest of the costs.

What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is “non-excepted.”

- “Non-excepted” medical treatment is any care that is voluntary and not required by any federal, state, or local law.
- “Excepted” medical treatment is any care that is not voluntary and is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan’s coverage of services is limited to non-religious aspects of care.
- Our plan will cover the services you get from this institution in your home, as long as they would be covered if given by home health agencies that are not religious non-medical health care institutions. If you get services from this institution that are provided to you in a facility, the following applies:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply. Please see the plan’s Benefits Chart (Chapter 4, Section D, page 35).

### L. How are your health care services covered when you are in a religious non-medical health care institution?

What is a religious non-medical health care institution?

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.
**M. Rules for owning durable medical equipment**

*Durable medical equipment* means certain items ordered by a provider for use in your own home. Examples of these items are oxygen equipment and supplies, wheelchairs, canes, crutches, walkers, and hospital beds.

**Will you own your durable medical equipment?**

You will always own certain items, such as prosthetics. In this section, we discuss durable medical equipment you must rent.

In Medicare, people who rent certain types of durable medical equipment own it after 13 months. As a member of Blue Cross Community MMAI, however, you usually will not own the rented equipment, no matter how long you rent it.

You and your Blue Cross Community MMAI Care Coordinator will decide on your medical equipment needs during your Comprehensive Health Risk Assessment meeting. If your need for durable medical equipment is only for a short time, Blue Cross Community MMAI can rent it.

In certain situations, we will transfer ownership of the durable medical equipment item if you have a long-term need and it is approved. Call Member Services to find out about the requirements you must meet and the papers you need to provide.

**What happens if you switch to Medicare?**

You will have to make 13 new payments in a row under Original Medicare to own the equipment if:

- you did not become the owner of the durable medical equipment item while you were in our plan and
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program.

The payments you made while you were in our plan do not count toward these 13 payments.

If you made payments for the durable medical equipment under Original Medicare before you joined our plan, those Medicare payments do not count toward the 13 payments. You will have to make 13 new payments in a row under Original Medicare to own the item.

There are no exceptions to this case when you return to Original Medicare.
Chapter 4: Benefits Chart

A. Understanding your covered services .......................................................... 34
B. Our plan does not allow providers to charge you for services .................. 34
C. About the Benefits Chart ........................................................................... 34
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E. Benefits not covered by the plan ................................................................. 58

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
A. Understanding your covered services

This chapter tells you what services Blue Cross Community MMAI covers. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5. This chapter also explains limits on some services.

Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plan’s rules. See Chapter 3, Section B, page 21 for details about the plan’s rules.

If you need help understanding what services are covered, call your Care Coordinator and/or Member Services at 1-877-723-7702 (TTY/TDD: 711) during these hours:

October 1 to February 14
8 a.m. to 8 p.m., Central time
Seven days a week

February 15 to September 30
8 a.m. to 8 p.m., Central time
Monday through Friday

B. Our plan does not allow providers to charge you for services

We do not allow Blue Cross Community MMAI providers to bill you for 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 service.

› You should never get a bill from a provider. If you do, see Chapter 7, Section A, page 76.

C. About the Benefits Chart

This benefits chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services. It is broken into two sections, General Services offered to all enrollees, and Home and Community-based Services offered to enrollees who qualify through a home and community-based services waiver program.

We will pay for the services listed in the Benefits Chart only when the following rules are met. You do not pay anything for the service listed in the Benefits Chart, as long as you meet the coverage requirements described below.

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3, Section D, page 25 has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can see other network providers. This is called a referral. Chapter 3, Section D, page 24 has more information about getting a referral and explains when you do not need a referral.
- 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. Covered services that need approval first are marked in the Benefits Chart by an asterisk (*).

All preventive services are free. You will see this apple next to preventive services in the benefits chart.
# D. The Benefits Chart

<table>
<thead>
<tr>
<th>General services that our plan covers</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal aortic aneurysm screening</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan will cover one ultrasound screening for people at risk. You must get a referral for it at your “Welcome to Medicare” preventive visit.</td>
<td></td>
</tr>
<tr>
<td><strong>Alcohol misuse screening and counseling</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.</td>
<td></td>
</tr>
<tr>
<td>If you screen positive for alcohol misuse, the plan covers up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance services</strong></td>
<td>$0</td>
</tr>
<tr>
<td>Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan.</td>
<td></td>
</tr>
<tr>
<td>In cases that are <em>not</em> emergencies, the plan <em>may</em> pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.</td>
<td></td>
</tr>
<tr>
<td><strong>Annual wellness visit</strong></td>
<td>$0</td>
</tr>
<tr>
<td>If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will cover this once every 12 months.</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first.</td>
<td></td>
</tr>
<tr>
<td><strong>Bone mass measurement</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will cover the services once every 24 months, or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.</td>
<td></td>
</tr>
</tbody>
</table>
### General services that our plan covers

<table>
<thead>
<tr>
<th>Service</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast cancer screening (mammograms)</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan will cover the following services:</td>
<td></td>
</tr>
<tr>
<td>• One baseline mammogram between the ages of 35 and 39</td>
<td></td>
</tr>
<tr>
<td>• One screening mammogram every 12 months for women age 40 and older</td>
<td></td>
</tr>
<tr>
<td>• Clinical breast exams once every 24 months</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac (heart) rehabilitation services</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor’s referral. The plan also covers <em>intensive</em> cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may:</td>
<td></td>
</tr>
<tr>
<td>• discuss aspirin use,</td>
<td></td>
</tr>
<tr>
<td>• check your blood pressure, or</td>
<td></td>
</tr>
<tr>
<td>• give you tips to make sure you are eating well.</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular (heart) disease testing</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. Additional testing may be covered if deemed medically necessary by your primary care provider.</td>
<td></td>
</tr>
<tr>
<td><strong>Cell phone</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers a cell phone for members with certain health conditions who do not have regular access to a phone. Your care coordinator must approve that you need a phone in your care plan.</td>
<td></td>
</tr>
<tr>
<td><strong>Cervical and vaginal cancer screening</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers the following services:</td>
<td></td>
</tr>
<tr>
<td>• For all women: Pap tests and pelvic exams once every 12 months</td>
<td></td>
</tr>
</tbody>
</table>

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## General services that our plan covers

<table>
<thead>
<tr>
<th>Description</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chiropractic services</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers adjustments of the spine to correct alignment. Six visits a year are covered.</td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal cancer screening</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers the following services:</td>
<td></td>
</tr>
<tr>
<td>• Flexible sigmoidoscopy (or screening barium enema) every 48 months</td>
<td></td>
</tr>
<tr>
<td>• Fecal occult blood test, every 12 months</td>
<td></td>
</tr>
<tr>
<td>• Screening colonoscopy</td>
<td></td>
</tr>
<tr>
<td>For people at high risk of colorectal cancer, the plan will cover one screening colonoscopy (or screening barium enema) every 24 months.</td>
<td></td>
</tr>
<tr>
<td>For people not at high risk of colorectal cancer, the plan will cover one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).</td>
<td></td>
</tr>
<tr>
<td>Additional screenings may be covered if deemed medically necessary by your primary care provider.</td>
<td></td>
</tr>
<tr>
<td><strong>Counseling to stop smoking or tobacco use</strong></td>
<td>$0</td>
</tr>
<tr>
<td>If you use tobacco but do not have signs or symptoms of tobacco-related disease:</td>
<td></td>
</tr>
<tr>
<td>• The plan will cover two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits.</td>
<td></td>
</tr>
<tr>
<td>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</td>
<td></td>
</tr>
<tr>
<td>• The plan will cover two counseling quit attempts within a 12 month period. However, you will pay a cost sharing amount. Each counseling attempt includes up to four face-to-face visits.</td>
<td></td>
</tr>
<tr>
<td>If you use tobacco and are pregnant:</td>
<td></td>
</tr>
<tr>
<td>• The plan will cover three counseling quit attempts within a 12 month period. This service is free for you. Each counseling attempt includes up to four face-to-face visits.</td>
<td></td>
</tr>
</tbody>
</table>
### General services that our plan covers

<table>
<thead>
<tr>
<th>Service</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Custodial nursing facility care</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan will cover skilled nursing facilities (SNF) and intermediate care facilities (ICF). The nursing facilities provide the following services:</td>
<td></td>
</tr>
<tr>
<td>• All staff, routine equipment and supplies including oxygen (if less than one tank has been furnished to the resident for the month in question)</td>
<td></td>
</tr>
<tr>
<td>• Room and board, supervision and oversight, and all laundry services</td>
<td></td>
</tr>
<tr>
<td>• Food substitutes and nutritional supplements</td>
<td></td>
</tr>
<tr>
<td>• Medications which are regularly available without prescription at a commercial pharmacy and which may be stocked by the facility under Department of Public Health regulations</td>
<td></td>
</tr>
<tr>
<td>• Certain over-the-counter drugs or items ordered by a physician</td>
<td></td>
</tr>
<tr>
<td>• Additional required services</td>
<td></td>
</tr>
</tbody>
</table>

| **Dental services**                          | $0                |
| The plan covers the following dental services: |                    |
| • Limited and comprehensive exams           |                    |
| • Restorations                              |                    |
| • Dentures                                  |                    |
| • Extractions                               |                    |
| • Sedation                                  |                    |
| • Dental emergencies                        |                    |
| • Dental services necessary for the health of a pregnant woman prior to delivery of her baby. |                    |
| In addition to the above dental services, Blue Cross Community MMAI also covers: |                    |
| • Two oral exams each year                  |                    |
| • Two preventative cleanings each year       |                    |
| • One set of X-rays each year                |                    |
| • $500 each year to use for additional comprehensive dental services. You can use this $500 toward things like dentures, fillings, and crowns. |                    |

| **Depression screening**                     | $0                |
| The plan will cover one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals. |                    |
### General services that our plan covers

<table>
<thead>
<tr>
<th>Service Description</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes screening</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan will cover this screening (includes fasting glucose tests) if you have any of the following risk factors:</td>
<td></td>
</tr>
<tr>
<td>• High blood pressure (hypertension)</td>
<td></td>
</tr>
<tr>
<td>• History of abnormal cholesterol and triglyceride levels (dyslipidemia)</td>
<td></td>
</tr>
<tr>
<td>• Obesity</td>
<td></td>
</tr>
<tr>
<td>• History of high blood sugar (glucose)</td>
<td></td>
</tr>
<tr>
<td>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.</td>
<td></td>
</tr>
</tbody>
</table>

| **Diabetic self-management training, services, and supplies**                      | $0                |
| The plan will cover the following services for all people who have diabetes (whether they use insulin or not): |                   |
| • Supplies to monitor your blood glucose, including the following:                 |                   |
|   – A blood glucose monitor                                                       |                   |
|   – Blood glucose test strips                                                     |                   |
|   – Lancet devices and lancets                                                    |                   |
|   – Glucose-control solutions for checking the accuracy of test strips and monitors |                   |
| • For people with diabetes who have severe diabetic foot disease, the plan will cover the following: |                   |
|   – One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, or |                   |
|   – One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) |                   |
| • The plan will also cover fitting the therapeutic custom-molded shoes or depth shoes. |                   |
| • The plan will cover training to help you manage your diabetes, in some cases.    |                   |
### General services that our plan covers

<table>
<thead>
<tr>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.</td>
</tr>
</tbody>
</table>

#### Emergency care

*Emergency care* means services that are:

- given by a provider trained to give emergency services, *and*
- needed to treat a medical emergency.

*A medical emergency* is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:

- placing the person’s health in serious risk; *or*
- serious harm to bodily functions; *or*
- serious dysfunction of any bodily organ or part; *or*
- in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:
  - There is not enough time to safely transfer the member to another hospital before delivery.
  - The transfer may pose a threat to the health or safety of the member or unborn child.

Emergency care is not covered outside the U.S. and its territories except in certain cases. Call for details.
### General services that our plan covers

<table>
<thead>
<tr>
<th>Family planning services</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. The plan will cover the following services:</td>
<td>$0</td>
</tr>
<tr>
<td>• Family planning exam and medical treatment</td>
<td></td>
</tr>
<tr>
<td>• Family planning lab and diagnostic tests</td>
<td></td>
</tr>
<tr>
<td>• Family planning methods (birth control pills, patch, ring, IUD, injections, implants)</td>
<td></td>
</tr>
<tr>
<td>• Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)</td>
<td></td>
</tr>
<tr>
<td>• Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions</td>
<td></td>
</tr>
<tr>
<td>• Treatment for sexually transmitted infections (STIs)</td>
<td></td>
</tr>
<tr>
<td>• Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.)</td>
<td></td>
</tr>
<tr>
<td>• Genetic counseling</td>
<td></td>
</tr>
<tr>
<td>• Folic acid supplements and prenatal vitamins ordered by prescription and dispensed by a pharmacy</td>
<td></td>
</tr>
</tbody>
</table>

The plan will also cover some other family planning services. However, you must see a provider in the plan’s network for the following services:

• Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)

• Treatment for AIDS and other HIV-related conditions

• Genetic testing

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### Health and wellness education programs

Covered Services include:

• Training to manage your diabetes

• Training on kidney disease

• Counseling to stop smoking

• Counseling on food and diet

$0

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If you have questions, please call Blue Cross Community MMAI at **1-877-723-7702 (TTY/TDD 711)**, 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit [www.bcbsilcommunitymmai.com](http://www.bcbsilcommunitymmai.com).
### General services that our plan covers

<table>
<thead>
<tr>
<th><strong>What you must pay</strong></th>
<th><strong>Hearing services</strong>*</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>The plan covers hearing and balance tests done by your provider when you have signs of hearing loss. These tests tell you whether you need medical care. They are covered as outpatient care when you get them from a doctor, audiologist, or other trained provider. The plan also covers the following:</td>
</tr>
<tr>
<td></td>
<td>• Hearing Aid Benefit Maximum Allowance of $1,500 which includes one or two hearing aids every three years.</td>
</tr>
<tr>
<td></td>
<td>• Hearing aids should include the following services:</td>
</tr>
<tr>
<td></td>
<td>– Fitting/orientation/checking of hearing aid</td>
</tr>
<tr>
<td></td>
<td>– Conformity evaluation</td>
</tr>
<tr>
<td></td>
<td>– Three year repair warranty</td>
</tr>
<tr>
<td></td>
<td>– 48 batteries per hearing aid</td>
</tr>
<tr>
<td></td>
<td>– Two additional follow-up visits after fitting and programming</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>What you must pay</strong></th>
<th><strong>HIV screening</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>The plan pays for one HIV screening exam every 12 months for people who:</td>
</tr>
<tr>
<td></td>
<td>• ask for an HIV screening test, or</td>
</tr>
<tr>
<td></td>
<td>• are at increased risk for HIV infection.</td>
</tr>
<tr>
<td></td>
<td>For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Home health agency care</strong>*</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan will cover the following services, and maybe other services not listed here:</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy, occupational therapy, and speech therapy</td>
<td></td>
</tr>
<tr>
<td>• Medical and social services</td>
<td></td>
</tr>
<tr>
<td>• Medical equipment and supplies</td>
<td></td>
</tr>
</tbody>
</table>

**If you have questions**, please call Blue Cross Community MMAI at **1-877-723-7702** (TTY/TDD **711**), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit [www.bcbsilcommunitymmai.com](http://www.bcbsilcommunitymmai.com).
### General services that our plan covers

<table>
<thead>
<tr>
<th>Hospice care</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>You can get care from any hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider. The plan will cover the following:</td>
<td>$0</td>
</tr>
<tr>
<td>- Drugs to treat symptoms and pain</td>
<td>When you are in a hospice program certified by Medicare, your hospice services and your Medicare Part A and B services related to your terminal illness are paid for by Medicare. Blue Cross Community MMAI does not pay for your services.</td>
</tr>
<tr>
<td>- Short-term respite care</td>
<td></td>
</tr>
<tr>
<td>- Home care, including home health aide services</td>
<td></td>
</tr>
<tr>
<td>- Occupational, physical and speech-language therapy services to control symptoms</td>
<td></td>
</tr>
<tr>
<td>- Counseling services</td>
<td></td>
</tr>
</tbody>
</table>

**For hospice services and services covered by Medicare Part A or B that relate to your terminal illness:**

- The hospice provider will bill Medicare for your services. Medicare will cover hospice services and any Medicare Part A or B services. You pay nothing for these services.

**For services covered by Medicare Part A or B that are not related to your terminal illness (except for emergency care or urgently needed care):**

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

**For services covered by Blue Cross Community MMAI but not covered by Medicare Part A or B:**

- Blue Cross Community MMAI will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal illness. You pay nothing for these services.

**For drugs that may be covered by Blue Cross Community MMAI’s Medicare Part D benefit:**

- Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5.

Note: If you need non-hospice care, you should call your Care Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal illness. Please call Blue Cross Community MMAI Member Services at 1-877-723-7702 (TTY/TDD 711) during these hours:
  - 8:00 a.m. until 8:00 p.m. CST
  - October 1 through February 14, seven days a week
  - February 15 through September 30, Monday through Friday

*If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.*
## General services that our plan covers

<table>
<thead>
<tr>
<th>What you must pay</th>
</tr>
</thead>
</table>

### Immunizations

The plan will cover the following services:

- Pneumonia vaccine
- Flu shots, once a year, in the fall or winter
- Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B
- Other vaccines if you are at risk and they meet Medicare Part B coverage rules

The plan will cover other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, Section C, page 74 to learn more.

### Inpatient hospital care*

Your doctor must tell the health plan that you are going to go into the hospital. You must use hospitals in the network except in an emergency. You may need to get approval first if it is not an emergency.

The plan will cover the following services, and maybe other services not listed here:

- Semi-private room (or a private room if it is medically necessary)
- Meals, including special diets
- Regular nursing services
- Costs of special care units, such as intensive care or coronary care units
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Needed surgical and medical supplies
- Appliances, such as wheelchairs
- Operating and recovery room services
- Physical, occupational, and speech therapy
- Inpatient substance abuse services
- Blood, including storage, blood components and administration thereof
- Physician services

You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.
## General services that our plan covers

<table>
<thead>
<tr>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
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</tbody>
</table>

### Inpatient hospital care*

In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or at a distant location outside the service area. If Blue Cross Community MMAI provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.

### Inpatient mental health care*

The plan will cover medically necessary psychiatric inpatient care at approved institutions.

### Inpatient services covered during a non-covered inpatient stay

If your inpatient stay is not reasonable and needed, the plan will not cover it. However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here:

- Doctor services
- Diagnostic tests, like lab tests
- X-ray, radium, and isotope therapy, including technician materials and services
- Surgical dressings
- Splints, casts, and other devices used for fractures and dislocations
- Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that:
  - Replace all or part of the function of an inoperative or malfunctioning internal body organ.
- Let, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient’s condition.
- Physical therapy, speech therapy, and occupational therapy.
### General services that our plan covers

<table>
<thead>
<tr>
<th>Kidney disease services and supplies*</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan will cover the following services:</td>
<td></td>
</tr>
<tr>
<td>• Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services.</td>
<td></td>
</tr>
<tr>
<td>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, Section B, page 4.</td>
<td></td>
</tr>
<tr>
<td>• Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care</td>
<td></td>
</tr>
<tr>
<td>• Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments</td>
<td></td>
</tr>
<tr>
<td>• Home dialysis equipment and supplies</td>
<td></td>
</tr>
<tr>
<td>• Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply</td>
<td></td>
</tr>
</tbody>
</table>

**Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” above.**

<table>
<thead>
<tr>
<th>Meal Benefit*</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Community MMAI has a meal benefit program. Members with certain chronic conditions may be eligible for up to 10 meals after being released from the hospital. Your Care Coordinator will assist with ordering your meals</td>
<td></td>
</tr>
</tbody>
</table>
## General services that our plan covers

<table>
<thead>
<tr>
<th>Medical equipment and related supplies*</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following general types of services and items are covered:</td>
<td>$0</td>
</tr>
<tr>
<td>- Nondurable medical supplies, such as surgical dressings, bandages, disposable syringes, incontinence supplies, ostomy supplies and enteral nutrition therapy</td>
<td></td>
</tr>
<tr>
<td>- Durable medical equipment, such as wheelchairs, crutches, walkers, hospital beds, IV infusion pumps and supplies, and humidifiers (for a definition of “Durable medical equipment,” see Chapter 12, page 132 of this handbook).</td>
<td></td>
</tr>
<tr>
<td>- Prosthetic and orthotic devices, compression stockings, shoe orthotics, arch supports, foot inserts</td>
<td></td>
</tr>
<tr>
<td>- Respiratory equipment and supplies, such as oxygen equipment, CPAP and BIPAP equipment</td>
<td></td>
</tr>
<tr>
<td>- Repair of durable medical equipment, prosthetic devices and orthotic devices</td>
<td></td>
</tr>
<tr>
<td>- Rental of medical equipment under circumstances where patient’s needs are temporary</td>
<td></td>
</tr>
<tr>
<td>To be eligible for reimbursement some services may be subject to prior approval and/or medical criteria. We will pay for all medically necessary durable medical equipment that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.</td>
<td></td>
</tr>
</tbody>
</table>

## Medical nutrition therapy

<table>
<thead>
<tr>
<th>Medical nutrition therapy</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when referred by your doctor. The plan will cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor’s referral. A doctor must prescribe these services and renew the referral each year if your treatment is needed in the next calendar year.</td>
<td>$0</td>
</tr>
</tbody>
</table>
### General services that our plan covers

<table>
<thead>
<tr>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
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</tbody>
</table>

#### Medicare Part B prescription drugs
These drugs are covered under Part B of Medicare. Blue Cross Community MMAI will cover the following drugs:

- Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoisis-stimulating agents (such as Epogen® or Procrit®)
- IV immune globulin for the home treatment of primary immune deficiency diseases

 › Chapter 5, Section A, page 62-64 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.

 › Chapter 6, Section A, page 72 explains what you pay for your outpatient prescription drugs through our plan.

#### Non-emergency transportation*
The plan will cover transportation for you to travel to or from your medical appointments if it is a covered service. The plan will also cover the cost of getting to a pharmacy after a visit to the doctor. Types of non-emergency transportation include:

- Ambulatory: sedan/taxi
- Paralift wheelchair equipped vehicle
- Stretcher

$0
### General services that our plan covers

<table>
<thead>
<tr>
<th>Service Description</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity screening and therapy to keep weight down</strong></td>
<td>$0</td>
</tr>
<tr>
<td>If you have a body mass index of 30 or more, the plan will cover counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient diagnostic tests and therapeutic services</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan will cover the following services, and maybe other services not listed here:</td>
<td></td>
</tr>
<tr>
<td>• X-rays</td>
<td></td>
</tr>
<tr>
<td>• Radiation (radium and isotope) therapy, including technician materials and supplies</td>
<td></td>
</tr>
<tr>
<td>• Lab tests</td>
<td></td>
</tr>
<tr>
<td>• Blood, blood components and administration thereof</td>
<td></td>
</tr>
<tr>
<td>• Other outpatient diagnostic tests</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient hospital services</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan pays for medically needed services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. The plan will cover the following services, and maybe other services not listed here:</td>
<td></td>
</tr>
<tr>
<td>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery</td>
<td></td>
</tr>
<tr>
<td>• Labs and diagnostic tests billed by the hospital</td>
<td></td>
</tr>
<tr>
<td>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it</td>
<td></td>
</tr>
<tr>
<td>• X-rays and other radiology services billed by the hospital</td>
<td></td>
</tr>
<tr>
<td>• Medical supplies, such as splints and casts</td>
<td></td>
</tr>
<tr>
<td>• Some screenings and preventive services</td>
<td></td>
</tr>
<tr>
<td>• Some drugs that you can’t give yourself</td>
<td></td>
</tr>
<tr>
<td>General services that our plan covers</td>
<td>What you must pay</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Outpatient mental health care</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan will cover mental health services provided by:</td>
<td></td>
</tr>
<tr>
<td>• a state-licensed psychiatrist or doctor,</td>
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<tr>
<td>• a clinical psychologist,</td>
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<tr>
<td>• a clinical social worker,</td>
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<tr>
<td>• a clinical nurse specialist,</td>
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<tr>
<td>• a nurse practitioner,</td>
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<tr>
<td>• a physician assistant,</td>
<td></td>
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<tr>
<td>• Community Mental Health Centers (CMHCs),</td>
<td></td>
</tr>
<tr>
<td>• Hospitals,</td>
<td></td>
</tr>
<tr>
<td>• Encounter rate clinics such as Federally Qualified Health Centers (FQHCs),</td>
<td></td>
</tr>
<tr>
<td>• DASA licensed substance abuse providers, or</td>
<td></td>
</tr>
<tr>
<td>• any other Medicare-qualified mental health care professional as allowed under applicable state laws.</td>
<td></td>
</tr>
<tr>
<td>The plan will cover the following types of outpatient mental health services:</td>
<td></td>
</tr>
<tr>
<td>• Clinic services provided under the direction of a physician</td>
<td></td>
</tr>
<tr>
<td>• Rehabilitation services recommended by a physician or Licensed Practitioner of the Healing Arts, such as mental health assessment, treatment planning, crisis intervention, therapy, and case management</td>
<td></td>
</tr>
<tr>
<td>• Day treatment services</td>
<td></td>
</tr>
<tr>
<td>• Outpatient hospital services, such as Clinic Option Type A and Type B services</td>
<td></td>
</tr>
<tr>
<td>• Substance abuse treatment</td>
<td></td>
</tr>
<tr>
<td>The specific services each provider type listed above can deliver and any utilization controls on such services shall be determined by the plan consistent with federal and state laws and all applicable policies and/or agreements.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| <strong>Outpatient rehabilitation services</strong>                        | $0                |
| The plan will cover physical therapy, occupational therapy, and speech therapy. | |
| You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | |</p>
<table>
<thead>
<tr>
<th>General services that our plan covers</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient substance abuse services</strong>*</td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers the following services:</td>
<td></td>
</tr>
<tr>
<td>• Outpatient services (group or individual)</td>
<td></td>
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<tr>
<td>• Intensive outpatient services (group or individual)</td>
<td></td>
</tr>
<tr>
<td>• Detoxification services</td>
<td></td>
</tr>
<tr>
<td>• Residential services</td>
<td></td>
</tr>
<tr>
<td>• Diagnostic Psychiatric Evaluation</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient surgery</strong>*</td>
<td>$0</td>
</tr>
<tr>
<td>The plan will cover outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</td>
<td></td>
</tr>
<tr>
<td><strong>Over-the-Counter Drugs &amp; Supplies - Supplemental personal health related items</strong></td>
<td></td>
</tr>
<tr>
<td>The plan covers certain over-the-counter drugs and supplies. A full listing of covered items is in the <em>List of Covered Drugs</em>. The plan will pay up to a $25 benefit, plus a $5 shipping fee per quarter. You may make one (1) order each quarter. Benefits or coverage do not carry over.</td>
<td></td>
</tr>
<tr>
<td><strong>Partial hospitalization services</strong>*</td>
<td>$0</td>
</tr>
<tr>
<td><em>Partial hospitalization</em> is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care you get in your doctor’s or therapist’s office. It can help keep you from having to stay in the hospital.</td>
<td></td>
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</tbody>
</table>
## General services that our plan covers

<table>
<thead>
<tr>
<th></th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician/provider services, including doctor’s office visits</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan will cover the following services:</td>
<td></td>
</tr>
<tr>
<td>• Medically necessary health care or surgery services given in places such as:</td>
<td></td>
</tr>
<tr>
<td>– physician’s office</td>
<td></td>
</tr>
<tr>
<td>– certified ambulatory surgical center</td>
<td></td>
</tr>
<tr>
<td>– hospital outpatient department</td>
<td></td>
</tr>
<tr>
<td>• Consultation, diagnosis, and treatment by a specialist</td>
<td></td>
</tr>
<tr>
<td>• Basic hearing and balance exams given by your primary care provider if your doctor orders it to see whether you need treatment</td>
<td></td>
</tr>
<tr>
<td>• Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in rural areas or other places approved by Medicare</td>
<td></td>
</tr>
<tr>
<td>• Second opinion by another network provider before a medical procedure</td>
<td></td>
</tr>
<tr>
<td>• Non-routine dental care. Covered services are limited to:</td>
<td></td>
</tr>
<tr>
<td>– surgery of the jaw or related structures,</td>
<td></td>
</tr>
<tr>
<td>– setting fractures of the jaw or facial bones,</td>
<td></td>
</tr>
<tr>
<td>– pulling teeth before radiation treatments of neoplastic cancer, or</td>
<td></td>
</tr>
<tr>
<td>– services that would be covered when provided by a physician.</td>
<td></td>
</tr>
<tr>
<td><strong>Podiatry services</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan will cover the following services:</td>
<td></td>
</tr>
<tr>
<td>• Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs).</td>
<td></td>
</tr>
<tr>
<td>• Routine foot care for members. You may need to get approval first for foot care that is not routine.</td>
<td></td>
</tr>
<tr>
<td><strong>Prostate cancer screening exams</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan will cover a digital rectal exam and a prostate specific antigen (PSA) test once every 12 months for:</td>
<td></td>
</tr>
<tr>
<td>• Men age 50 and older</td>
<td></td>
</tr>
<tr>
<td>• African American men age 40 and older</td>
<td></td>
</tr>
<tr>
<td>• Men age 40 and older with a family history of prostate cancer</td>
<td></td>
</tr>
</tbody>
</table>

**If you have questions**, please call Blue Cross Community MMAI at **1-877-723-7702** (TTY/TDD **711**), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit [www.bcbsilcommunitymmai.com](http://www.bcbsilcommunitymmai.com).
<table>
<thead>
<tr>
<th>General services that our plan covers</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prosthetic devices and related supplies</strong>*</td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td>Prosthetic devices replace all or part of a body part or function. The plan will cover the following prosthetic devices, and maybe other devices not listed here:</td>
<td></td>
</tr>
<tr>
<td>- Colostomy bags and supplies related to colostomy care</td>
<td></td>
</tr>
<tr>
<td>- Pacemakers</td>
<td></td>
</tr>
<tr>
<td>- Braces</td>
<td></td>
</tr>
<tr>
<td>- Prosthetic shoes</td>
<td></td>
</tr>
<tr>
<td>- Artificial arms and legs</td>
<td></td>
</tr>
<tr>
<td>- Breast prostheses (including a surgical brassiere after a mastectomy)</td>
<td></td>
</tr>
<tr>
<td>The plan will also cover some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices.</td>
<td></td>
</tr>
<tr>
<td>The plan offers some coverage after cataract removal or cataract surgery. See “Vision Care” later in this section for details.</td>
<td></td>
</tr>
</tbody>
</table>

| **Pulmonary rehabilitation services*** | **$0** |
| The plan will cover pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have a referral for pulmonary rehabilitation from the doctor or provider treating the COPD. | |

| **Sexually transmitted infections (STIs) screening and counseling** | **$0** |
| The plan will cover screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. | |
| The plan will also cover up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. The plan will cover these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor’s office. | |
### General services that our plan covers

<table>
<thead>
<tr>
<th>Urgently needed care</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgently needed care</strong> is care given to treat:</td>
<td>$0</td>
</tr>
<tr>
<td>• a non-emergency, <strong>or</strong></td>
<td></td>
</tr>
<tr>
<td>• a sudden medical illness, <strong>or</strong></td>
<td></td>
</tr>
<tr>
<td>• an injury, <strong>or</strong></td>
<td></td>
</tr>
<tr>
<td>• a condition that needs care right away.</td>
<td></td>
</tr>
</tbody>
</table>

If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.

Urgent care is not covered outside of the United States and its territories.

<table>
<thead>
<tr>
<th>Vision care</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan covers the following:</td>
<td>$0</td>
</tr>
<tr>
<td>• Annual routine eye exams</td>
<td></td>
</tr>
<tr>
<td>• Eye glasses (lenses and frames) limited to one pair in a 24 month period</td>
<td></td>
</tr>
<tr>
<td>• An added $130 upgrade toward non-standard frame every two years</td>
<td></td>
</tr>
<tr>
<td>• Custom-made artificial eye</td>
<td></td>
</tr>
<tr>
<td>• Low vision devices</td>
<td></td>
</tr>
</tbody>
</table>

To be eligible for reimbursement some services may be subject to prior approval and/or medical criteria.

The plan covers outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. This includes treatment for age-related macular degeneration.

For people at high risk of glaucoma, the plan covers one glaucoma screening each year. People at high risk of glaucoma include:

• people with a family history of glaucoma,
• people with diabetes, and
• African-Americans who are age 50 and older

The plan covers one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) The plan also covers corrective lenses, and frames, and replacements if you need them after a cataract removal without a lens implant.
## General services that our plan covers

<table>
<thead>
<tr>
<th><strong>What you must pay</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
</tr>
</tbody>
</table>

### “Welcome to Medicare” Preventive Visit

The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes:

- a review of your health,
- education and counseling about the preventive services you need (including screenings and shots), and
- referrals for other care if you need it.

**Important:** We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.

## Home and community-based services that our plan covers

<table>
<thead>
<tr>
<th><strong>What you must pay</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
</tr>
</tbody>
</table>

### Adult day service

The plan covers structured day activities at a program of direct care and supervision if you qualify. This service:

- Provides personal attention
- Promotes social, physical and emotional well-being

### Assisted living

If you qualify, the Supportive Living Facility provides an alternative to Nursing Facility placement. Some of the services include the following:

- Assistance with activities of daily living
- Nursing services
- Personal care
- Medication administration
- Housekeeping
- 24 hour response/security staff

### Habilitation – day

The plan covers day habilitation, which assists with the retention or improvement in self help, socialization and adaptive skills outside the home if you qualify.
<table>
<thead>
<tr>
<th>Home and community-based services that our plan covers</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home delivered meals</td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers prepared meals brought to your home if you qualify.</td>
<td></td>
</tr>
<tr>
<td>Home health aide</td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers services from a home health aide, under the supervision of a registered nurse (RN) or other professional, if you qualify. Services may include the following:</td>
<td></td>
</tr>
<tr>
<td>• Simple dressing changes</td>
<td></td>
</tr>
<tr>
<td>• Assistance with medications</td>
<td></td>
</tr>
<tr>
<td>• Activities to support skilled therapies</td>
<td></td>
</tr>
<tr>
<td>• Routine care of prosthetic and orthotic devices</td>
<td></td>
</tr>
<tr>
<td>Home modifications*</td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include:</td>
<td></td>
</tr>
<tr>
<td>• Ramps</td>
<td></td>
</tr>
<tr>
<td>• Grab-bars</td>
<td></td>
</tr>
<tr>
<td>• Doorway widening</td>
<td></td>
</tr>
<tr>
<td>Homemaker services</td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers home care services provided in your home or community if you qualify. These services may include the following:</td>
<td></td>
</tr>
<tr>
<td>• A worker to help you with laundry</td>
<td></td>
</tr>
<tr>
<td>• A worker to help you with cleaning</td>
<td></td>
</tr>
<tr>
<td>• Training to improve your community living skills</td>
<td></td>
</tr>
<tr>
<td>Personal assistant</td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers a personal assistant to help you with activities of daily living if you qualify. These include, for example:</td>
<td></td>
</tr>
<tr>
<td>• Bathing</td>
<td></td>
</tr>
<tr>
<td>• Feeding</td>
<td></td>
</tr>
<tr>
<td>• Dressing</td>
<td></td>
</tr>
<tr>
<td>• Laundry</td>
<td></td>
</tr>
</tbody>
</table>

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
### Home and community-based services that our plan covers

<table>
<thead>
<tr>
<th>Service</th>
<th>What you must pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Private duty nursing services</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers shift and intermittent nursing services by a registered nurse (RN) or licensed practical nurse (LPN) if you qualify.</td>
<td></td>
</tr>
<tr>
<td><strong>Respite care</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers respite services to provide relief for an unpaid family member or primary caregiver who meet all of your service needs if you qualify. Certain limitations apply.</td>
<td></td>
</tr>
<tr>
<td>*<em>Specialized durable medical equipment and supplies</em></td>
<td>$0</td>
</tr>
<tr>
<td>If you qualify, the plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily living or to perceive, control, or communicate with the environment in which you live. Services might include:</td>
<td></td>
</tr>
<tr>
<td>• Hoyer lift</td>
<td></td>
</tr>
<tr>
<td>• Shower benches/chairs</td>
<td></td>
</tr>
<tr>
<td>• Stair lift</td>
<td></td>
</tr>
<tr>
<td>• Bed rails</td>
<td></td>
</tr>
<tr>
<td>*<em>Therapies</em></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers occupational, physical, and speech therapy if you qualify. These therapies focus on long term habilitative needs rather than short term acute restorative needs.</td>
<td></td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>$0</td>
</tr>
<tr>
<td>The plan covers training to help you get paid or unpaid jobs.</td>
<td></td>
</tr>
</tbody>
</table>

*For more information, visit [www.bcbsilcommunitymmai.com](http://www.bcbsilcommunitymmai.com).
E. Benefits not covered by the plan

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not cover these benefits.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this Member Handbook). Medicare and Medicaid will not cover them either. If you think that we should cover a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9, Section 5, page 95.

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this Member Handbook, the following items and services are not covered by our plan:

- Services considered not “reasonable and necessary,” according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
- Services that are provided without a required referral or approval.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See pages 30-31 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare pays for it.
- A private room in a hospital, except when it is medically needed.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Reversal of sterilization procedures and sex change operations.
- Acupuncture.
- Naturopath services (the use of natural or alternative treatments).
- Services provided in a state psychiatric hospital as a result of a legal commitment.
- Services provided through a Local Education Agency (LEA).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. Members are still responsible for their cost sharing amounts.
- If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.

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If you have questions, please call Blue Cross Community MA at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
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Chapter 5: Getting your outpatient prescription drugs through the plan

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medicaid.

Blue Cross Community MMAI also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, see the Benefits Chart in Chapter 4, Section D, page 35.

Rules for the plan’s outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
   - You generally must use a network pharmacy to fill your prescription.

2. Your prescribed drug must be on the plan’s List of Covered Drugs. We call it the “Drug List” for short.
   - If it is not on the Drug List, we may be able to cover it by giving you an exception. See Chapter 9, Section 6.2, page 103 to learn about asking for an exception.

3. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain reference books.

Selected prescription and over-the-counter (OTC) medications and medical supplies that are used to treat covered illnesses or injuries are included in plan benefits.
A. Getting your prescriptions filled

Fill your prescription at a network pharmacy
In most cases, the plan will pay for prescriptions only if they are filled at the plan’s network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

To find a network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services or your Care Coordinator.

Show your plan ID card when you fill a prescription
To fill your prescription, show your plan ID card at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug.

If you do not have your plan ID card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to pay you back. If you cannot pay for the drug, contact Member Services right away. We will do what we can to help.

To learn how to ask us to pay you back, see Chapter 7, Section B, page 77.

If you need help getting a prescription filled, you can contact Member Services or your Care Coordinator.

What if the pharmacy you use leaves the network?
If the pharmacy you use leaves the plan’s network, you will have to find a new network pharmacy.

To find a new network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services or your Care Coordinator.

What if you need a specialized pharmacy?
Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home. Usually, long-term care facilities have their own pharmacies. Residents may get prescription drugs through a facility’s pharmacy as long as it is part of our network. If your long-term care facility’s pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that supply drugs requiring special handling and instructions on their use.

To find a specialized pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services or your Care Coordinator.
Can you use mail-order services to get your drugs?

Our plan’s mail-order service allows you to order up to a 30-day supply. A 30-day supply has the same copay as a one-month supply.

To get order forms and information about filling your prescriptions by mail, or to ask for a refill of prescriptions on file, you may:

- Mail your prescriptions to PrimeMail or
- Have your prescriber call in, fax or email a new prescription.
- For refills, you may call PrimeMail and speak with a trained Member Services Agent or use our automated voice system.

Usually, a mail-order prescription will get to you in 14 days. If your order is delayed and you are at risk of running out of your drugs, please call Member Services to get approval. Once approval is given, we can send your prescription to the pharmacy of your choice. We can also have your prescriber call in a shorter supply to the pharmacy.

To reach PrimeMail Customer Service, call 1-877-277-7895, 24 hours a day, seven (7) days a week. TTY/TDD users should call 711.

How do I fill my prescriptions by mail?

Usually, a mail-order prescription will get to you within 14 days. There are three ways to order refills:

- online, by phone or through the mail.

How will the mail-order service process my prescription?

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider’s office, and refills on your mail-order prescriptions:

1. New prescriptions the pharmacy receives from you
   The pharmacy will automatically fill and deliver new prescriptions it receives from you.

2. New prescriptions the pharmacy receives directly from your provider’s office
   After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. Refills on mail-order prescriptions
   For refills, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

Can you get a long-term supply of drugs?

This plan does not offer long-term supplies of drugs.
Can you use a pharmacy that is not in the plan’s network?

Generally, we pay for drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- You are traveling outside your Plan’s service area and you:
  - run out of or lose your covered drugs; or
  - become ill and need a covered drug; or
  - cannot reach a network pharmacy.
- You are unable to get a covered drug in a timely manner in your service area because, for example, there is no network pharmacy in a reasonable driving distance that provides 24/7 service;
- You are filling a prescription for a covered drug and that drug (such as an orphan drug or other specialty drug) is not stocked at a nearby network retail or mail-order pharmacy;
- You are given covered drugs from a pharmacy in an emergency room, provider-based clinic, or other outpatient setting.
- Any federal disaster or other public health emergency has been declared in which you are displaced from your residence and cannot be expected to get your covered drugs at a network pharmacy.
- Access to your usual pharmacy is not available.

In these cases, please check first with Member Services to see if there is a network pharmacy nearby.

Will the plan pay you back if you pay for a prescription?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost when you get your prescription. You can ask us to pay you back.

To learn more about this, see Chapter 7, Section A, page 76.

B. The plan’s Drug List

The plan has a List of Covered Drugs. We call it the “Drug List” for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan’s Drug List as long as you follow the rules explained in this chapter.

What is on the Drug List?

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter drugs covered under your Medicaid benefits. The Drug List includes both brand-name and generic drugs. Generic drugs have the same ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

We will generally cover a drug on the plan’s Drug List as long as you follow the rules explained in this chapter.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

How can you find out if a drug is on the Drug List?

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan’s website at www.bcbsilcommunitymmai.com. The Drug List on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan’s Drug List or to ask for a copy of the list.

What is not on the Drug List?

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.
Blue Cross Community MMAI Plan will not pay for the drugs listed in this section except for certain drugs covered under our enhanced drug coverage. These are called excluded drugs. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9, Section 5.3, page 97.)

Here are three general rules for excluded drugs:

- Our plan’s outpatient drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B. Drugs that would be covered under Medicare Part A or Part B are covered under our plan’s medical benefit.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- The use of the drug must be either approved by the Food and Drug Administration or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid.

- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

C. Limits on coverage for some drugs

Why do some drugs have limits?

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plan expects your provider to use the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, see Chapter 9, Section 6.2, page 103.
What kinds of rules are there?

1. Limiting use of a brand-name drug when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. If there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version.

However, if your provider has told us the medical reason that the generic drug will not work for you, or has written “No substitutions” on your prescription for a brand-name drug, or has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from Blue Cross Community MMAI before you fill your prescription. If you don’t get approval, Blue Cross Community MMAI may not cover the drug.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first.

If Drug A does not work for you, the plan will then cover Drug B. This is called step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. For example, the plan might limit:

- how many refills you can get, or
- how much of a drug you can get each time you fill your prescription

Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services or check our website at www.bcbsilcommunitymmai.com.
D. Why your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- **The drug you want to take is not covered by the plan.** The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.

- **The drug is covered, but there are special rules or limits on coverage for that drug.** As explained in the section above, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

**You can get a temporary supply**

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you have been taking:
   - is no longer on the plan’s Drug List, or
   - was never on the plan’s Drug List, or
   - is now limited in some way

2. You must be in one of these situations:
   - You were in the plan last year and do not live in a long-term care facility. We will cover up to a 30-day supply of your new drug or less if your prescription is written for fewer days. You must fill the prescription at a network pharmacy.
   - You are new to the plan and do not live in a long-term care facility.
   - You were in the plan last year and live in a long-term care facility. We will cover up to a 30-day supply of your new drug or less if your prescription is written for fewer days. You must fill the prescription at a network pharmacy.
   - You are new to the plan and live in a long-term care facility. We will cover up to a 30-day supply of your new drug or less if your prescription is written for fewer days. You must fill the prescription at a network pharmacy.
   - You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away. We will cover up to a 31-day supply or less if your prescription is written for fewer days.
   - You have been in the plan and are entering or leaving a long-term care facility. Sometimes a prescribed drug may not be on the Drug List. This can happen when you’re moving from one treatment setting to another. In such a case, you must use our exceptions and appeals process. We’ll handle your case as quickly as your health condition requires. In these cases, a limited supply can be given to you by the facility when you go home. To prevent a gap in care, you are also permitted to have a full supply to use at home to continue treatment. This benefit is available before discharge from a Part A stay. When you are entering or leaving a long-term care facility, and do not have access to your remaining drugs, we will make sure you have a refill. We can do this one time for each drug needed. Early refills will not limit access to your benefit, so you can still get a refill.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- **You can change to another drug.**
  There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- **You can ask for an exception.**
  You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

To learn more about asking for an exception, see Chapter 9, Section 6.2, page 103.

If you need help asking for an exception, you can contact Member Services or your Care Coordinator.

### E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, the plan might make changes to the Drug List during the year. The plan might:

- Add drugs because new drugs, including generic drugs, became available or the government approved a new use for an existing drug.
- Remove drugs because they were recalled or because cheaper drugs work just as well.
- Add or remove a limit on coverage for a drug.
- Replace a brand-name drug with a generic drug.

If any of the changes below affect a drug you are taking, the change will not affect you until January 1 of the next year:

- We put a new limit on your use of the drug.
- We remove your drug from the Drug List, but not because of a recall or because a new generic drug has replaced it.

Before January 1 of the next year, you usually will not have an increase in your payments or added limits to your use of the drug. The changes will affect you on January 1 of the next year.

In the following cases, you will be affected by the coverage change before January 1:

- If a brand name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days’ notice about the change.
  - The plan may give you a 60-day refill of your brand-name drug at a network pharmacy.
  - You should work with your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
  - You and your provider can ask the plan to continue covering the brand-name drug for you. To learn how, see Chapter 9, Section 6.2, page 103.

- If a drug is recalled because it is found to be unsafe or for other reasons, the plan will remove the drug from the Drug List. We will tell you about this change right away.
  - Your provider will also know about this change. He or she can work with you to find another drug for your condition.

If there is a change in coverage for a drug you are taking, the plan will send you a notice. Normally, the plan will let you know at least 60 days before the change.
F. Drug coverage in special cases

If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a copay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care facility, you may get your prescription drugs through the facility’s pharmacy if it is part of our network.

Check your Provider and Pharmacy Directory to find out if your long-term care facility’s pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

If you are in a long-term care facility and become a new member of the plan

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 91 days of your membership, until we have given you a 98-day supply. The first supply will be for up to a 31-day supply, or less if your prescription is written for fewer days. If you need refills, we will cover them during your first 91 days in the plan.

If you have been a member of the plan for more than 90 days and you need a drug that is not on our Drug List, we will cover one 31-day supply. We will also cover one 31-day supply if the plan has a limit on the drug’s coverage. If your prescription is written for fewer than 31 days, we will pay for the smaller amount.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. A different drug covered by the plan might work just as well for you. Or, you and your provider can ask the plan to make an exception and cover the drug in the way you would like it to be covered.

To learn more about asking for exceptions, see Chapter 9, Section 6.2, page 103.

If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan. If you are enrolled in a Medicare hospice and require a drug not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, see Chapter 4.
G. Programs on drug safety and managing drugs

Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

- Drug errors
- Drugs that may not be needed because you are taking another drug that does the same thing
- Drugs that may not be safe for your age or gender
- Drugs that could harm you if you take them at the same time
- Drugs that are made of things you are allergic to

If we see a possible problem in your use of prescription drugs, we will work with your provider to correct the problem.

Programs to help members manage their drugs

If you take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You’ll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You’ll also get a personal medication list that will include all the medications you’re taking and why you take them.

It’s a good idea to schedule your medication review before your yearly “Wellness” visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication Therapy Management programs are voluntary and free to members who qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

▷ If you have any questions about these programs, please contact Member Services or your Care Coordinator.
Chapter 6: What you pay for your Medicare and Medicaid prescription drugs

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If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Introduction

This chapter tells what you pay for your outpatient prescription drugs. By “drugs,” we mean:

- Medicare Part D prescription drugs, and
- drugs and items covered under Medicaid, and
- drugs and items covered by the plan as additional benefits.

Because you are eligible for Medicaid, you are getting “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

To learn more about prescription drugs, you can look in these places:

- The plan’s List of Covered Drugs. We call this the “Drug List.” It tells you:
  - Which drugs the plan pays for
  - Whether there are any limits on the drugs
  If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at www.bcbsilcommunitymmai.com. The Drug List on the website is always the most current.
- Chapter 5 of this Member Handbook. Chapter 5, Section A, page 62 tells how to get your outpatient prescription drugs through the plan. It includes rules you need to follow. It also tells which types of prescription drugs are not covered by our plan.
- The plan’s Provider and Pharmacy Directory. In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan. The Provider and Pharmacy Directory has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, Section A, page 62.

A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your out-of-pocket costs. This is the amount of money you, or others paying for you, pay for your prescriptions.
- Your total drug costs. This is the amount of money you, or others paying for you, pay for your prescriptions, plus the amount the plan pays.

When you get prescription drugs through the plan, we send you a report called the Explanation of Benefits. We call it the EOB for short. The EOB includes:

- Information for the month. The report tells what prescription drugs you got. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- “Year-to-date” information. This is your total drug costs and the total payments made since January 1.

We offer coverage of drugs not covered under Medicare. Payments made for these drugs will not count towards your total out-of-pocket costs. We also pay for some over-the-counter drugs. You do not have to pay anything for these drugs. To find out which drugs our plan covers, see the Drug List.
B. Keeping track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your plan ID card.

Show your plan ID card every time you get a prescription filled. This will help us know what prescriptions you fill and what you pay.

2. Make sure we have the information we need.

Give us copies of receipts for drugs that you have paid for. You can ask us to pay you back for the drug.

Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit
- When you pay a copay for drugs that you get under a drug maker’s patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

To learn how to ask us to pay you back for the drug, see Chapter 7, Section B, page 77.

3. Send us information about the payments others have made for you.

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. Check the reports we send you.

When you get an Explanation of Benefits in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Member Services. Be sure to keep these reports. They are an important record of your drug expenses.
C. Vaccinations

Our plan covers Medicare Part D vaccines. There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of the vaccine itself. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of giving you the shot.

Before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

• We can tell you about how your vaccination is covered by our plan.

We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies are pharmacies that have agreed to work with our plan. A network provider is a provider who works with the health plan. A network provider should work with Blue Cross Community MMAI to ensure that you do not have any upfront costs for a Part D vaccine.

How much you pay for a Medicare Part D vaccination

What you pay for a Medicare Part D vaccination depends on three things:

1. What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).
   • Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, see the Benefits Chart in Chapter 4.
   • Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan’s Drug List.
2. Where you get the vaccine itself
3. Who gives you the shot

Sometimes you will have to pay the entire cost for both the vaccine itself and for getting the shot. You can ask our plan to pay you back. Other times, you will pay nothing.

› To learn how to ask us to pay you back, see Chapter 7, Section B, page 77.

Here are three common ways you might get a Medicare Part D vaccination:

1. You buy the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
   • You will pay nothing for the vaccine.
   • Our plan will pay for the cost of giving you the shot.

2. You get the Medicare Part D vaccination at your doctor’s office and the doctor gives you the shot.
   • You will pay nothing to the doctor for the vaccine.
   • Our plan will pay for the cost of giving you the shot.
   • The doctor’s office should call our plan in this situation so we can make sure they know you only have to pay nothing for the vaccine.

3. You get the Medicare Part D vaccine itself at a pharmacy and take it to your doctor’s office to get the shot.
   • You will pay nothing for the vaccine.
   • Our plan will pay for the cost of giving you the shot.

› To learn how to ask us to pay you back, see Chapter 7, Section B, page 77.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
A. When you can ask us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your services and drugs already received. A network provider is a provider who works with the health plan. If you get a bill for health care or drugs, send the bill to us. To send us a bill, see page 77,

• If the services or drugs are covered, we will pay the provider directly.
• If the services or drugs are covered and you already paid the bill, we will pay you back. It is your right to be paid back if you paid for the services or drugs.
• If the services or drugs are not covered, we will tell you.

Contact Member Services or your Care Coordinator if you have any questions. If you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask our plan to pay you back or to pay a bill you got:

1. When you get emergency or urgently needed health care from an out-of-network provider

You should ask the provider to bill the plan.

• If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
• You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill and proof of any payment you made.
  – If the provider should be paid, we will pay the provider directly.
  – If you have already paid for the service, we will pay you back.

2. When a network provider sends you a bill

Network providers must always bill the plan.

• Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
• If you have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, you will have to pay the full cost of your prescription.

In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back. Please see Chapter 5, Section A, page 64 to learn more about out-of-network pharmacies.

4. When you pay the full cost for a prescription because you do not have your plan ID card with you

If you do not have your plan ID card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.

• Send us a copy of your receipt when you ask us to pay you back.
5. When you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on the plan’s List of Covered Drugs (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
  - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (see Chapter 9, Section 5.2, page 96).
  - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (see Chapter 9, Section 5.2, page 96).

- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for the drug.
- When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision.
  - To learn how to make an appeal, see Chapter 9, Section 4, page 93.

B. How and where to send us your request for payment

Send us your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. It is a good idea to make a copy of your bill and receipts for your records. You can ask your care coordinator for help.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You do not have to use the form, but it will help us process the information faster.
- You can get a copy of the form on our website www.bcbsilcommunitymmai.com, or you can call Member Services and ask for the form.

Mail your request for payment together with any bills or receipts to us at this address:

For Medical claims, mail your request for payment together with any bills or receipts to us at this address:

Blue Cross Community MMAI
P.O. Box 805107,
Chicago, IL 60680

For Prescription Drug claims, mail your request for payment together with any bills or receipts to us at this address:

Blue Cross Community MMAI
P.O. Box 14429,
Lexington, KY 40512

You may also call our plan to request payment at 1-877-723-7702 (TTY/TDD: 711)

- October 1 to February 14
  8:00 a.m. until 8:00 p.m., Central time
  Seven days a week

- February 15 to September 30
  8:00 a.m. until 8:00 p.m., Central time
  Monday through Friday

You must submit your claim to us within 180 days of the date you got the service, item, or drug.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
C. We will make a coverage decision

When we get your request for payment, we will make a coverage decision. This means that we will decide whether your health care or drug is covered by the plan. We will also decide the amount, if any, you have to pay for the health care or drug.

- We will let you know if we need more information from you.
- If we decide that the health care or drug is covered and you followed all the rules for getting it, we will pay for it. If you have already paid for the service or drug, we will mail you a check for what you paid. If you have not paid for the service or drug yet, we will pay the provider directly.

Chapter 3, Section B, page 21 explains the rules for getting your services covered. Chapter 5, Section A, page 62 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.

To learn more about coverage decisions, see Chapter 9, Section 5.2, page 96.

D. You can make an appeal

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called making an appeal. You can also make an appeal if you do not agree with the amount we pay.

The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, see Chapter 9, Section 4, page 93.

- If you want to make an appeal about getting paid back for a health care service, go to Chapter 9, Section 5.5, page 101.
- If you want to make an appeal about getting paid back for a drug, go to Chapter 9, Section 5.5, page 101.
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If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights.

A. You have a right to get information in a way that meets your needs

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

- To get information in a way that you can understand, call Member Services. Our plan has people who can answer questions in different languages. You can get this document in Spanish, or speak with someone about this information in other languages for free. We can also give you information in Braille, large print, and other ways.

- If you are having trouble getting information from our plan because of language problems or a disability 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 file a complaint with Medicaid by calling the Illinois Health Benefits Hotline at 1-800-226-0768. TTY users should call 1-877-204-1012.

A. Usted tiene el derecho de recibir la información de la manera que usted necesita.

Nosotros tenemos que informarle sobre los beneficios del plan y sus derechos de manera que usted los pueda entender. Nosotros tenemos que informarle sobre sus derechos cada año en el que usted participa en nuestro plan.

- Para recibir información de manera que usted la pueda entender, por favor llame al número de Servicio para Miembros. Nuestro plan cuenta con personas quienes pueden responder a preguntas en diferentes idiomas. Usted puede obtener este documento en español o hablar con alguien, de forma gratuita, acerca de esta información en otros idiomas. Nosotros también le podemos dar la información en Braille, impresa en letra grande, y de otras maneras.

- Si usted está teniendo dificultades en recibir información de parte de nuestro plan por causa de problemas de idioma o por una discapacidad y usted quiere montar una querella, por favor llame a las oficinas de Medicare al número 1-800-MEDICARE (1-800-633-4227). Usted puede llamar las 24 horas del día, los siete días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. Usted también puede montar una querella con la oficina de Medicaid al llamar a la Línea de Ayuda de Beneficios de Salud de Illinois (Illinois Health Benefits Hotline) al 1-800-226-0768. Los usuarios de TTY deben llamar al número 1-877-204-1012.
B. We must treat you with respect, fairness, and dignity at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against members because of any of the following:

- Race
- Ethnicity
- National origin
- Religion
- Sex
- Sexual orientation
- Age
- Mental ability
- Behavior
- 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

Under the rules of the plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation.

We cannot deny services to you or punish you for exercising your rights.

- For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services’ [Office for Civil Rights](https://www.hhs.gov/ocr/) at 1-800-368-1019 (TTY 1-800-537-7697). You can also call your local Office for Civil Rights at the Illinois Department of Human Rights 1-312-814-4320.

- If you have a disability and need help accessing care or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. We must ensure that you get timely access to covered services and drugs

As a member of our plan:

- 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.
  - Call Member Services or look in the [Provider and Pharmacy Directory](https://www.bcbsilcommunitymmai.com) to learn which doctors are accepting new patients.

- You have the right to go to a gynecologist or another women’s health specialist 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. To learn about out-of-network providers, see Chapter 3, Section D, page 25.
  - If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.

▷ Chapter 9, Section 10, page 117 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9, Sections 4 and 5 also tell what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.
D. 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 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.

How we protect your health information

- We make sure that unauthorized people do not see or change your records.

- In most situations, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

- There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on our quality of care.
  - We are required to give Medicare your health and drug information. If Medicare releases your information for research or other uses, it will be done according to Federal laws.

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.

- 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.

If you have questions or concerns about the privacy of your personal health information, call Member Services.
E. We must give you information about the plan, its network providers, and your covered services

As a member of Blue Cross Community MMAI, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at 1-877-723-7702 (TTY/TDD: 711). This is a free service. Member Services also has free language interpreter services available for non-English speakers and hearing impaired. We can also give you information in Braille, large print, and other ways. Contact Member Services for information in these alternative formats.

If you want any of the following, call Member Services:

- **Information about how to choose or change plans**
- **Information about our plan, including:**
  - Financial information
  - How the plan has been rated by plan members
  - The number of appeals made by members
  - How to leave the plan
- **Information about our network providers and our network pharmacies, including:**
  - How to choose or change primary care providers
  - The qualifications of our network providers and pharmacies
  - How we pay the providers in our network

For a list of providers and pharmacies in the plan’s network, see the Provider and Pharmacy Directory. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at www.bcbsilcommunitymmai.com.

- **Information about covered services and drugs and about rules you must follow, including:**
  - Services and drugs covered by the plan
  - Limits to your coverage and drugs
  - 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:**
  - Asking us to put in writing why something is not covered
  - Asking us to change a decision we made
  - Asking us to pay for a bill you have received

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
F. 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. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7, Section A, page 76.

G. You have the right to leave the plan at any time
No one can make you stay in our plan if you do not want to. You can leave the plan at any time. If you leave our plan, you will still be in the Medicare and Medicaid programs.
You have the right to get your Medicare benefits through:
- A different Medicare-Medicaid plan
- Original Medicare
- A Medicare Advantage plan

You can get your Medicare Part D prescription drug benefits from:
- A different Medicare-Medicaid plan
- A prescription drug plan
- A Medicare Advantage plan

You can get your Medicaid benefits through:
- A different Medicare-Medicaid plan
- Medicaid fee-for-service

Important Note: If you are receiving long term care or home and community based waiver services, you must either stay with our plan or choose another plan to receive your long term supports and services.

H. You have a right to make decisions about your health care
You have the right to know your treatment options and make decisions about your health care
You have the right to get full information from your doctors and other health care providers when you get services. Your providers must explain your condition and your treatment choices in a way that you can understand.

- Know your choices. You have the right to be told about all the kinds of treatment.
- Know the risks. You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- You can get a second opinion. You have the right to see another doctor before deciding on treatment.
- You can say “no.” You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- You can ask us to explain why a provider denied care. You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- You can ask us to cover a service or drug that was denied or is usually not covered. Chapter 9, Section 4, page 93 tells how to ask the plan for a coverage decision.
You have the right to say what you want to happen if you are unable to make health care decisions for yourself.

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to give someone the right to make health care decisions for you.
- Give your doctors written instructions about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an advance directive. There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

To learn more about advance directives in Illinois, go to the Illinois Department of Public Health’s website at: www.idph.state.il.us/public/books/advin.htm.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid such as the Illinois Department of Aging Senior Helpline (1-800-252-8966 or aging.ilsenior@illinois.gov) may also have advance directive forms.

- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.

- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

- **Blue Cross Community MMAI will make your completed form part of your medical record.** Blue Cross Community MMAI cannot, as a condition of treatment, require you to fill out or waive an advance directive.

If you are going to be hospitalized and you have signed an advance directive, take a copy of it to the hospital.

- The hospital 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.

**Remember, it is your choice to fill out an advance directive or not.**

**What to do if your instructions are not followed**

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint by calling the Senior Helpline at 1-800-252-8966. TTY users should call 1-888-206-1327.
I. You have the right to make complaints and to ask us to reconsider decisions we have made

Chapter 9, Section 3, page 92 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

What to do if you believe you are being treated unfairly or your rights are not being respected

If you believe you have been treated unfairly—and it is not about discrimination for the reasons listed on page 81—you can get help in these ways:

- You can call Member Services.
- You can call the Senior Health Insurance Program. For details about this organization and how to contact it, see Chapter 2, Section E, page 14.
- You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You can call the Senior Helpline at 1-800-252-8966. TTY users should call 1-888-206-1327.

How to get more information about your rights

There are several ways to get more information about your rights:

- You can call Member Services.
- You can call the Senior Health Insurance Program. For details about this organization and how to contact it, see Chapter 2, Section E, page 14.
- You can contact Medicare.
  - You can visit the Medicare website to read or download “Medicare Rights & Protections.” (Go to www.medicare.gov/Publications/Pubs/pdf/11534.pdf.)
  - Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You can call the Senior Helpline at 1-800-252-8966. TTY users should call 1-888-206-1327.
J. You also have responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the Member Handbook** to learn what is covered and what rules you need to follow to get covered services and drugs.
  - For details about your covered services, see Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - For details about your covered drugs, see Chapters 5 and 6.

- **Tell us about any other health or prescription drug coverage you have.** Please call Member Services to let us know.
  - We are required to make sure that you are using all of your coverage options when you receive health care. This is called *coordination of benefits*.
  - For more information about coordination of benefits, see Chapter 1, Section K, page 6.

- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan ID card whenever you get services or drugs.

- **Help your doctors and other health care providers give you the best care.**
  - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor’s office, hospitals, and other providers’ offices.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most Blue Cross Community MMAI members, Medicaid pays for your Part A premium and for your Part B premium.
  - If you get any services or drugs that are not covered by our plan, you must pay the full cost.

If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9, Section 4, page 93 to learn how to make an appeal.

- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
  - **If you move outside of our plan service area, you cannot be a member of our plan.** Chapter 1, Section D, page 3 tells about our service area. We can help you figure out whether you are moving outside our service area. We can let you know if we have a plan in your new area. Also, be sure to let Medicare and Medicaid know your new address when you move. See Chapter 2, Sections G and H, pages 16-17 for phone numbers for Medicare and Medicaid.
  - **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.

- **Call Member Services for help if you have questions or concerns.**
Chapter 9: What to do if you have a problem or complaint (Coverage Decisions, Appeals, Complaints)

What’s in this chapter?

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

You should receive the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. If you are having a problem with your care, you can call the Senior HelpLine at 1-800-252-8966, TTY: 1-888-206-1327. This chapter will explain the options you have for different problems and complaints, but you can always call the Senior HelpLine to help guide you through your problem. The Senior Helpline will help anyone at any age enrolled in this plan.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Chapter 9: What to do if you have a problem or complaint (Coverage Decisions, Appeals, Complaints)

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If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Chapter 9: What to do if you have a problem or complaint
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If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Section 1: Introduction

Section 1.1: What to do if you have a problem

This chapter will tell you what to do if you have a problem with your plan or with your services or payment. These processes have been approved by Medicare and Medicaid. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 1.2: What about the legal terms?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

Section 2.1: Where to get more information and help

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the Senior HelpLine

If you need help getting started, you can always call the Senior HelpLine. The Senior HelpLine can answer your questions and help you understand what to do to handle your problem. The Senior HelpLine is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the Senior HelpLine is 1-800-252-8966, TTY 1-888-206-1327. The services are free and are available to you no matter how old you are.

You can get help from the Senior Health Insurance Program (SHIP)

You can also call the Senior Health Insurance Program (SHIP). The SHIP counselors can answer your questions and help you understand what to do to handle your problem. The SHIP counselors can help you no matter how old you are. The SHIP is not connected with us or with any insurance company or health plan. The SHIP services are free. The SHIP phone number is 1-800-548-9034, TTY 1-866-323-5321.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven (7) days a week.
- TTY 1-877-486-2048. The call is free.
- Visit the Medicare website (http://www.medicare.gov).

Getting help from Medicaid

You can call the State of Illinois directly for help with problems. Call the Illinois Health Benefits Hotline at 1-800-226-0768, TTY 877-204-1012. The call is free.

You can also call the Quality Improvement Organization (QIO). In Illinois, this is Telligen QIO, at 1-800-647-8089, TTY/TDD 711. This is a group of doctors and other health care providers who help improve the quality of care for people with Medicare. It is not connected with our plan.
Section 3: Problems with your Benefits

Section 3.1: Should you use the process for Coverage Decisions and Appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

<table>
<thead>
<tr>
<th>Is your problem or concern about your benefits or coverage?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)</td>
<td></td>
</tr>
<tr>
<td><strong>Yes.</strong></td>
<td><strong>No.</strong></td>
</tr>
<tr>
<td>My problem is about benefits or coverage.</td>
<td>My problem is not about benefits or coverage.</td>
</tr>
</tbody>
</table>

Go to the next section of this chapter, Section 4, “Coverage Decisions and Appeals.”

Skip ahead to Section 10 at the end of this chapter: “How to make a complaint.”
Section 4: Coverage Decisions and Appeals

Section 4.1: Overview of Coverage Decisions and Appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

What is a Coverage Decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service is covered by Medicare or Medicaid, either of you can ask for a coverage decision before the doctor gives the service.

What is an Appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service or drug that you want is not covered or is no longer covered by Medicare or Medicaid. If you or your doctor disagree with our decision, you can appeal.

Section 4.2: Getting help with Coverage Decisions and Appeals

Who can I call for help asking for Coverage Decisions or making an Appeal?

You can ask any of these people for help:

- You can call us at Member Services, 1-877-723-7702 (TTY/TDD: 711), during these hours:
  - 8:00 a.m. until 8:00 p.m. CT
  - October 1 through February 14, seven days a week
  - February 15 through September 30, Monday through Friday

- Call the Illinois Health Benefits Hotline for free help. The Illinois Health Benefits Hotline helps people enrolled in Medicaid with problems. The phone number is 1-800-226-0768, TTY: 1-877-204-1012.

- Call the Senior HelpLine for free help. The Senior HelpLine will help anyone at any age enrolled in this plan. The Senior HelpLine is an independent organization. It is not connected with this plan. The phone number is 1-800-252-8966, TTY: 1-888-206-1327.

- Talk to your doctor or other provider. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
  - If you want your doctor or other provider to be your representative, call Member Services and ask for the “Appointment of Representative” form. You can also get the form on the Medicare website at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf. The form will give the person permission to act for you. You must give us a copy of the signed form.
  - Note that under the Medicare program, your doctor or other provider can file an appeal without the “Appointment of Representative” form.
Talk to a friend or family member and ask him or her to act for you. You can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.

- If you want a friend, relative, or other person to be your representative, call Member Services and ask for the “Appointment of Representative” form. You can also get the form on the Medicare website at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf. The form will give the person permission to act for you. You must give us a copy of the signed form.

- You also have the right to ask a lawyer to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.

- However, you do not have to have a lawyer to ask for any kind of coverage decision or to make an appeal.

Section 4.3: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. You only need to read the section that applies to your problem:

- **Section 5** gives you information if you have problems about services and drugs (but not Part D drugs). For example, use this section if:
  - You are not getting medical care you want, and you believe that this care is covered by our plan.
  - We did not approve services or drugs that your doctor wants to give you, and you believe that this care should be covered.

  **NOTE:** Only use Section 5 if these are drugs not covered by Part D. Drugs in the *List of Covered Drugs* with an “MC” are not covered by Part D. See Section 6 for Part D drug appeals.

- You received medical care or services that you think should be covered, but we are not paying for this care.

- You got and paid for medical services you thought were covered, and you want to ask us to pay you back.

- You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.

**NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8.

- **Section 6** gives you information about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a Part D drug that is not on the plan’s *List of Covered Drugs* (Drug List).
  - You want to ask us to waive limits on the amount of the drug you can get.
  - You want to ask us to cover a drug that requires prior approval.
  - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)

- **Section 7** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Section 8 gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you’re not sure which section you should be using, please call Member Services at 1-877-723-7702 (TTY/TDD: 711), during these hours:

- 8:00 a.m. until 8:00 p.m. CT
- October 1 through February 14, seven days a week
- February 15 through September 30, Monday through Friday

You can also get help or information from the Senior HelpLine by calling 1-800-252-8966, TTY: 1-888-206-1327.

Section 5: Problems about services and drugs (not Part D drugs)

Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long term care services. You can also use this section for problems with drugs that are not covered by Part D. Drugs in the List of Covered Drugs with an “MC” are not covered by Part D. Use Section 6 for Part D drug appeals.

This section tells what you can do if you are in any of the five following situations:

1. You think the plan covers a medical, behavioral health or long-term care service that you need but are not getting.

   What you can do: You can ask the plan to make a coverage decision. Go to Section 5.2 (page 96) for information on asking for a coverage decision.

2. The plan did not approve care your doctor wants to give you, and you think it should have.

   What you can do: You can appeal the plan’s decision to not approve the care. Go to Section 5.3 (page 97) for information on making an appeal.

3. You received services that you think the plan covers, but the plan will not pay.

   What you can do: You can appeal the plan’s decision not to pay. Go to Section 5.4 (page 99) for information on making an appeal.

4. You got and paid for medical services you thought were covered, and you want the plan to reimburse you for the services.

   What you can do: You can ask the plan to pay you back. Go to Section 5.5 (page 101) for information on asking the plan for payment.

5. Your coverage for a certain service is being reduced or stopped, and you disagree with our decision.

   What you can do: You can appeal the plan’s decision to reduce or stop the service.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 to find out more.

   In all cases where we tell you that medical care you have been getting will be stopped, use the information in Section 5.2 of this chapter as your guide for what to do.
Section 5.2: Asking for a Coverage Decision

How to ask for a Coverage Decision to get a medical, behavioral health or long-term care service

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: 1-877-723-7702, TTY: 711.
- You can fax us at: 1-855-674-9193
- You can write to us at: PO Box 805107, Chicago, IL 60680-4112

How long does it take to get a Coverage Decision?

It usually takes up to 14 days after you asked. If we don’t give you our decision within 14 days, you can appeal. Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more days.

Can I get a Coverage Decision faster?

Yes. If you need a response faster because of your health, you should ask us to make a “fast coverage decision.” If we approve the request, we will notify you of our decision within 72 hours.

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more days.

The legal term for “fast coverage decision” is “expedited determination.”

Asking for a fast Coverage Decision:

You must meet the following two requirements to get a fast coverage decision:

- You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
- You can get a fast coverage decision only if the standard 14 day deadline could cause serious harm to your health or hurt your ability to function.

If your doctor says that you need a fast coverage decision, we will automatically give you one.

If you ask for a fast coverage decision, without your doctor’s support, we will decide if you get a fast coverage decision.

- If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 day deadline instead.
- This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
Chapter 9: What to do if you have a problem or complaint (Coverage Decisions, Appeals, Complaints)

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.

If the Coverage Decision is Yes, when will I get the service?

You will be able to get the service within 14 days (for a standard coverage decision) or 72 hours (for a fast coverage decision) of when you asked. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.

If the Coverage Decision is No, how will I find out?

If the answer is No, we will send you a letter telling you our reasons for saying No.

• If we say No, you have the right to ask us to reconsider – and change – this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.

• If you decide to make an appeal, it means you are going on to Level 1 of the Appeals process (see Section 5.3 below).

Section 5.3: Level 1 Appeal for services and drugs (not Part D drugs)

What is an Appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagrees with our decision, you can appeal.

In all cases, you must start your appeal at Level 1.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

If we tell you after our review that the service is not covered, your case can go to a Level 2 Appeal.

How do I make a Level 1 Appeal?

• To start your appeal, you, your doctor or other provider, or your representative must contact us. You can call us at 1-877-723-7702 (TTY/TDD: 711). For additional details on how to reach us for appeals, see Chapter 2, page 9.

• You can ask us for a “standard appeal” or a “fast appeal.”

• If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
  – You can submit a request to the following address:
    – P.O. Box 27838, Albuquerque, NM 87125-9705
  – You may also ask for an appeal by calling us at 1-877-723-7702 (TTY/TDD: 711).

The legal term for “fast appeal” is “expedited reconsideration.”

Can someone else make the Appeal for me?

Yes. Your doctor, other provider, or someone else can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get a Appointment of Representative form, call Member Services and ask for one, or visit the Medicare website at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.

If the appeal comes from someone besides you, we usually must receive the completed Appointment of Representative form before we can review the appeal.

Note that under the Medicare program, your doctor or other provider can file an appeal without the Appointment of Representative form.

How much time do I have to make an Appeal?

You must ask for an appeal within 60 calendar days from the date on the letter we sent to tell you our decision. However, if you are appealing a service that is only covered by Medicaid and want your benefits to continue during the appeal, you will need to submit your appeal within 10 calendar days after you receive the Notice of Adverse Action. Go to page 99 for more information about continuing your benefits.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

Can I get a copy of my case file?

Yes. Ask us for a copy.
Can my doctor give you more information about my Appeal?
Yes, you and your doctor may give us more information to support your appeal.

How will the plan make the Appeal decision?
We take a careful look at all of the information about your request for coverage of medical care. Then, we check to see if we were following all the rules when we said No to your request. The reviewer will be someone who did not make the original decision.
If we need more information, we may ask you or your doctor for it.

When will I hear about a “Standard” Appeal decision?
We must give you our answer within 15 business days after we get your appeal. We will give you our decision sooner if your health condition requires us to.

• However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell you by letter.

• If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.

• If we do not give you an answer within 15 business days or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about a service covered by Medicare or both Medicare and Medicaid. You will be notified when this happens. If your problem is about a service covered only by Medicaid, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

If our answer is Yes to part or all of what you asked for, we must approve or give the coverage within 72 hours after we give you our answer.

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about a service covered by Medicare or both Medicare and Medicaid, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about a service covered only by Medicaid, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

What happens if I ask for a fast Appeal?
If you ask for a fast appeal, we will let you know within 24 hours after we receive your request if we need more information to decide your appeal. We will make a decision on your fast appeal within 24 hours after receiving all of the required information from you.

• However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell you by letter.

• If we do not give you an answer within 24 hours after receiving all required information or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about a service covered by Medicare or both Medicare and Medicaid. You will be notified when this happens. If your problem is about a service covered only by Medicaid, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

If our answer is Yes to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we make our decision.

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about a service covered by Medicare or both Medicare and Medicaid, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about a service covered only by Medicaid, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.
**Chapter 9: What to do if you have a problem or complaint (Coverage Decisions, Appeals, Complaints)**

**Will my benefits continue during Level 1 Appeals?**

If your problem is about a service covered by Medicare or both Medicare and Medicaid, your benefits for that service will continue during the Level 1 Appeal process.

If your problem is about a service covered only by Medicaid, your benefits for that service will not continue unless you ask the plan to continue your benefits when you appeal. You must submit your appeal and request to continue benefits within 10 calendar days after you receive the Notice of Adverse Action. If you lose the appeal, you may have to pay for the service.

**Section 5.4: Level 2 Appeal for services and drugs (not Part D drugs)**

If the plan says *No* at Level 1, what happens next?

If we say “no” to your appeal at Level 1, we will send you a letter. This letter will tell you if the service was a Medicare and/or Medicaid service.

- If your problem is about a **Medicare** service, we will automatically send your case to Level 2 of the Medicare appeals process as soon as the Level 1 Appeal is complete.

- If your problem is about a **Medicaid** service, you can file a Level 2 Appeal yourself with the State Fair Hearings office. The letter will tell you how to do this. Information is also below.

- If your problem is about a service that could be **covered by both Medicare and Medicaid**, we will automatically send your case to Level 2 of the Medicare appeals process. If they also say “no” to your appeal, you can ask for another Level 2 Appeal with the State Fair Hearings office.

**What is a Level 2 Appeal?**

A Level 2 Appeal is the second appeal, which is done by an independent organization that is not connected to the plan. It is either an Independent Review Entity (IRE) or it is a Medicaid State Fair Hearings office.

**My problem is about a Medicaid service. How can I make a Level 2 Appeal?**

Level 2 of the appeals process for Medicaid services is a State Fair Hearing. You must ask for a State Fair Hearing in writing or over the phone within 30 calendar days of receiving our decision letter on your Level 1 Appeal. The letter you get from us will provide information about where to submit your hearing request.

- If you want to ask for a State Fair Hearing related to a standard Medicaid item or service, the Aging Waiver (Community Care Program, or CCP), or the Supportive Living Facilities Waiver, submit your appeal in writing or over the phone to:

  **MAIL**
  Illinois Healthcare and Family Services
  Bureau of Administrative Hearings
  Fair Hearings Section
  69 West Washington, 4th Floor
  Chicago, Illinois 60602

  **CALL**
  855-418-4421 (toll free)

  **TTY**
  800-526-5812

  **FAX**
  312-793-2005

  **EMAIL**
  hfs.fairhearings@illinois.gov

- If you want to ask for a State Fair Hearing related to the Persons with Disabilities Waiver, Traumatic Brain Injury Waiver, or the HIV/AIDS Waiver (Home Services Program, or HSP), submit your appeal in writing or over the phone to:

  **WRITE**
  Department of Human Services
  Bureau of Hearings
  69 West Washington, 4th Floor
  Chicago, Illinois 60602

  **CALL**
  800-435-0774 (toll free)

  **TTY**
  877-734-7429

  **FAX**
  312-793-8573

  **EMAIL**
  dhs.bahnewappeal@illinois.gov

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*If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit [www.bcbsilcommunitymmai.com](http://www.bcbsilcommunitymmai.com).*
The hearing will be handled by an Impartial Hearing Officer authorized to oversee State Fair Hearings. You will get a letter from the Hearings office telling you the date, time, and place of the hearing. This letter will also provide detailed information about the hearing. It is important that you read this letter carefully. At least three business days before the hearing, you will get a packet of information from Blue Cross Community MMAI. This packet will include all the evidence we will present at the hearing. This packet will also be sent to the Impartial Hearing Officer.

You will need to tell the Hearings office of any reasonable accommodations you may need. If because of your disability you cannot participate in person at the local office, you may ask to participate by phone. Please provide the Hearings staff with the phone number to best reach you. You must provide all the evidence you will present at the hearing to the Impartial Hearing Officer at least three days before the hearing. This includes a list of any witnesses who will appear, as well as all documents you will use. The hearing will be recorded.

My problem is about a service that is covered by Medicare or both Medicare and Medicaid.

What will happen at the Level 2 Appeal?

If we say “no” to your Appeal at Level 1 and the service is usually covered by Medicare or both Medicare and Medicaid, you will automatically get a Level 2 Appeal from the Independent Review Entity (IRE). The IRE will do a careful review of the Level 1 decision, and decide whether it should be changed.

- You do not need to request the Level 2 Appeal with the Independent Review Entity. We will automatically send your case. You will be notified when this happens.
- The Independent Review Entity is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file.

The Independent Review Entity must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal. This rule applies if you sent your appeal before getting medical services.

- However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

If you had “fast appeal” at Level 1, you will automatically have a fast appeal at Level 2. The review organization must give you an answer within 72 hours of when it gets your appeal.

- However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

How will I find out about the decision?

If your Level 2 Appeal was a State Fair Hearing, the State Fair Hearings office will send you a letter explaining its decision called a “Final Administrative Decision.”

If your Level 2 Appeal went to the Independent Review Entity, it will send you a letter explaining its decision.

- If the Independent Review Entity says Yes to part or all of what you asked for, we must authorize the medical care coverage within 72 hours or give you the service within 14 calendar days from the date we receive the IRE’s decision.
- If the Independent Review Entity says No to part or all of what you asked for, it means they agree with the Level 1 decision. This is called “upholding the decision.” It is also called “turning down your appeal.”

If the decision is No for all or part of what I asked for, can I make another appeal?

If your Level 2 Appeal went to the State Fair Hearings office, and you disagree with the decision, you cannot make another appeal on the same issue to the State Fair Hearings office. The decision is reviewable only through the Circuit courts of the State of Illinois.

If your Level 2 Appeal went to the Independent Review Entity, you may be able to appeal again in certain situations:

- If your problem is about a service that is covered by both Medicare and Medicaid, you can ask for another Level 2 Appeal with the State Fair Hearings office. After the IRE makes its decision, we will send you a letter telling you about your right to ask for a State Fair Hearing. Go to page 99 for information on the State Fair Hearing process.
Chapter 9: What to do if you have a problem or complaint (Coverage Decisions, Appeals, Complaints)

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.

- If your problem is about a service that is covered by Medicare or by both Medicare and Medicaid, you can appeal after Level 2 only if the dollar value of the service you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

See Section 9 of this chapter for more information on your appeal rights after Level 2.

Will my benefits continue during Level 2 appeals? Maybe.

- If your problem is about a service covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the IRE.

- If your problem is about a service covered by Medicaid only, your benefits for that service will continue if you submit a Level 2 Appeal within 10 calendar days after receiving the plan’s decision letter.

- If your problem is about a service covered by both Medicare and Medicaid, your benefits for that service will continue during the Level 2 appeal process with the IRE. If you submit the appeal to the State Fair Hearings office after the IRE makes its decision, your benefits will continue if you file your appeal within 10 calendar days of the notice from the IRE.

Section 5.5: Payment problems

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: Asking us to pay a bill you have gotten for covered services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

How do I ask the plan to pay me back for medical services I paid for?

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service you paid for is a covered service, and we will check to see if you followed all the rules for using your coverage.

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for your medical care within 60 calendar days after we get your request.

- Or, if you haven’t paid for the services yet, we will send the payment directly to the provider. When we send the payment, it’s the same as saying Yes to your request for a coverage decision.

- If the medical care is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service, and explaining why.

What if the plan says they will not pay?

If you do not agree with our decision, you can make an appeal. Follow the appeals process described in Section 5.3. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.

- If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.

If we answer “no” to your appeal and the service is usually covered by Medicare or both Medicare and Medicaid, we will automatically send your case to the Independent Review Entity. We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days.

- If the IRE says No to your appeal, it means they agree with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”) The letter you get will explain additional appeal rights you may have.

If we answer “no” to your appeal and the service is usually covered by Medicaid only, you can file a Level 2 Appeal yourself (see Section 5.4 of this chapter).
Section 6: Part D drugs

Section 6.1: What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are “Part D drugs.” There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. This section only applies to Part D drug appeals.

- The List of Covered Drugs (Drug List), includes some drugs with an “MC”. These drugs are not Part D drugs. Appeals or coverage decisions about drugs with the “MC” symbol follow the process in Section 5.

Can I ask for a Coverage Decision or make an Appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan’s List of Covered Drugs (Drug List)
  - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan’s Drug List but we require you to get approval from us before we will cover it for you).
  - Please note: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

The legal term for a coverage decision about your Part D drugs is “coverage determination.”

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Use the chart below to help you determine which part has information for your situation:

<table>
<thead>
<tr>
<th>Which of these situations are you in?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need a drug that isn’t on our Drug List or need us to waive a rule or restriction on a drug we cover?</td>
<td>You can ask us to make an exception. (This is a type of coverage decision.) Start with Section 6.2 of this chapter. Also see Sections 6.3 and 6.4.</td>
</tr>
<tr>
<td>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</td>
<td>You can ask us for a coverage decision. Skip ahead to Section 6.4 of this chapter.</td>
</tr>
<tr>
<td>Do you want to ask us to pay you back for a drug you have already received and paid for?</td>
<td>You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to Section 6.4 of this chapter.</td>
</tr>
<tr>
<td>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</td>
<td>You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section 6.5 of this chapter.</td>
</tr>
</tbody>
</table>
Section 6.2: What is an exception?

An *exception* is permission to get coverage for a drug that is not normally on our List of Covered Drugs, or to use the drug without certain rules and limitations. If a drug is not on our List of Covered Drugs, or is not covered in the way you would like, you can ask us to make an “exception.”

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List).
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5, Section C, page 65.

- The extra rules and restrictions on coverage for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting plan approval before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
  - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
  - Quantity limits. For some drugs, the plan limits the amount of the drug you can have.

*The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception.”*

Section 6.3: Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for, and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say *Yes* to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say *No* to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 (page 106) tells how to make an appeal if we say *No*.

The next section tells you how to ask for a coverage decision, including an exception.
Section 6.4: How to ask for a Coverage Decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 1-877-723-7702 (TTY/TDD: 711).

- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

- Read Section 4 (page 93) to find out how to give permission to someone else to act as your representative.
  - You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.

- If you want to ask us to pay you back for a drug, read Chapter 7, Section A, page 76 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- If you are requesting an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”

- Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

AT A GLANCE: How to ask for a Coverage Decision about a drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 days.

- If you are asking for an exception, include the supporting statement from the doctor or other prescriber.

- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)

Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
If your health requires it, ask us to give you a “fast Coverage Decision”
We will use the “standard deadlines” unless we have agreed to use the “fast deadlines.”

- A standard coverage decision means we will give you an answer within 72 hours after we get your doctor’s statement.
- A fast coverage decision means we will give you an answer within 24 hours.
  - You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
  - If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision, and the letter will tell you that.
  - If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether you get a fast coverage decision.
  - If we decide to give you a standard decision, we will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision. You can file a “fast complaint” and get a decision within 24 hours.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

The legal term for “fast coverage decision” is “expedited coverage determination.”

Deadlines for a “fast Coverage Decision”
- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor’s or prescriber’s statement supporting your request. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an outside independent organization will review your request and our decision.
  - If our answer is Yes to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor’s or prescriber’s statement supporting your request.
  - If our answer is No to part or all of what you asked for, we will send you a letter that explains why we said No. The letter will also explain how you can appeal our decision.

Deadlines for a “standard Coverage Decision” about a drug you have not yet received
- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request or, if you are asking for an exception, after we get your doctor’s or prescriber’s supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review the decision.
  - If our answer is Yes to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor’s or prescriber’s supporting statement.
  - If our answer is No to part or all of what you asked for, we will send you a letter that explains why we said No. The letter will also explain how you can appeal our decision.
Deadlines for a “standard Coverage Decision” about payment for a drug you have already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review the decision.
  - **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
  - **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said No. This statement will also explain how you can appeal our decision.

Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at **1-877-723-7702** (TTY/TDD: **711**).
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request within 60 calendar days from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

**The legal term for an appeal to the plan about a Part D drug coverage decision is plan “redetermination.”**

### AT A GLANCE: How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.
- Ask within 60 calendar days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.

Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- You can ask for a copy of the information in your appeal and add more information.
- You have the right to ask us for a copy of the information about your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 (page 104) of this chapter.

**The legal term for “fast appeal” is “expedited reconsideration.”**
Chapter 9: What to do if you have a problem or complaint (Coverage Decisions, Appeals, Complaints)

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said No to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast appeal”

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review our decision.
  - If our answer is Yes to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
  - If our answer is No to part or all of what you asked for, we will send you a letter that explains why we said No.

Deadlines for a “standard appeal”

- If we are using the standard deadlines, we must give you our answer within seven (7) calendar days after we get your appeal, or sooner if your health requires it. If you think your health requires it, you should ask for a “fast appeal.”
- If we do not give you a decision within seven (7) calendar days, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review our decision.
  - If our answer is Yes to part or all of what you asked for:
    - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than seven (7) calendar days after we get your appeal.
    - If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.
  - If our answer is No to part or all of what you asked for, we will send you a letter that explains why we said No and tells how to appeal our decision.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Section 6.6: Level 2 Appeal for Part D drugs

If we say No to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity will review our decision.

- If you want the Independent Review Entity to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.

- When you make an appeal to the Independent Review Entity, we will send them your case file. You have the right to ask us for a copy of your case file.

- You have a right to give the Independent Review Entity other information to support your appeal.

- The Independent Review Entity is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.

- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

Deadlines for “fast appeal” at Level 2

- If your health requires it, ask the Independent Review Entity for a “fast appeal.”

- If the review organization agrees to give you a “fast appeal,” it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.

- If the Independent Review Entity says Yes to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

AT A GLANCE: How to make a Level 2 Appeal

If you want the Independent Review Organization to review your case, your appeal request must be in writing:

- Ask within 60 days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.

- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.

Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

Deadlines for “standard appeal” at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity must give you an answer to your Level 2 Appeal within seven (7) calendar days after it gets your appeal.

- If the Independent Review Entity says Yes to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.

- If the Independent Review Entity approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity agrees with our decision not to approve your request. This is called “upholding the decision.” It is also called “turning down your appeal.”

If the dollar value of the drug coverage you want meets a certain minimum amount, you can make another appeal at Level 3. The letter you get from the Independent Review Entity will tell you the dollar amount needed to continue with the appeals process. The Level 3 Appeal is handled by an administrative law judge.
Chapter 9: What to do if you have a problem or complaint (Coverage Decisions, Appeals, Complaints)

Section 7: Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your “discharge date.” Our plan's coverage of your hospital stay ends on this date.
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called An Important Message from Medicare about Your Rights. If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven (7) days a week. TTY users should call 1-877-486-2048. The call is free.

Read this notice carefully and ask questions if you don’t understand. The Important Message tells you about your rights as a hospital patient, including:

- Your right to get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be a part of any decisions about the length of your hospital stay.
- Your right to know where to report any concerns you have about the quality of your hospital care.
- Your right to appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does not mean you agree to the discharge date told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at 1-877-723-7702 (TTY/TDD: 711). You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, seven (7) days a week. TTY users should call 1-877-486-2048. The call is free.
- You can also see the notice online at www.cms.gov/BNI/12HospitalDischargeAppealNotices.asp.

If you need help, please call Member Services at 1-877-723-7702 (TTY/TDD: 711). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven (7) days a week. TTY users should call 1-877-486-2048. The call is free.

Section 7.2: Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

To make an appeal to change your discharge date call the Telligen QIO at 1-800-647-8089.

Call right away!

Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date. An Important Message from Medicare about Your Rights contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do not call to appeal, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section 8.4 (page 115).

We want to make sure you understand what you need to do and what the deadlines are.

- Ask for help if you need it. If you have questions or need help at any time, please call Member Services at 1-877-723-7702 (TTY/TDD: 711). You can also call the Senior HelpLine. The phone number is 1-800-252-8966, TTY: 1-888-206-1327.

What is a Quality Improvement Organization?
It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a “fast review”
You must ask the Quality Improvement Organization for a “fast review” of your discharge. Asking for a “fast review” means you are asking for the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term for “fast review” is “immediate review.”

What happens during the review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Section 7.3: Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review within 60 calendar days after the day when the Quality Improvement Organization said No to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

You can reach the Telligen QIO at: 1-800-647-8089 TTY/TDD 711.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days, the Quality Improvement Organization reviewers will make a decision

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you have received since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Review Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Review Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Section 7.4: What happens if I miss an Appeal deadline?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

AT A GLANCE: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a “fast review” of your hospital discharge date.

We will give you our decision within 72 hours.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a “fast review.”
- If we say Yes to your fast review,
  - it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.
  - It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.
- If we say No to your fast review,
  - we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
  - If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you got after the planned discharge date.
If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.

– To make sure we were following all the rules when we said No to your fast appeal, we will send your appeal to the “Independent Review Entity.” When we do this, it means that your case is automatically going to Level 2 of the appeals process.

_The legal term for “fast review” or “fast appeal” is “expedited appeal.”_

**Level 2 Alternate Appeal to change your hospital discharge date**

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 (page 117) of this chapter tells how to make a complaint.

During the Level 2 Appeal, the Independent Review Entity reviews the decision we made when we said No to your “fast review.” This organization decides whether the decision we made should be changed.

• The Independent Review Entity does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

• The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.

• Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal of your hospital discharge.

• If the Independent Review Entity says Yes to your appeal, then we must pay you back for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your hospital services for as long as it is medically necessary.

• If this organization says No to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.

• The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

**AT A GLANCE: How to make a Level 2 Alternate Appeal**

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.
Section 8: What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
  - With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
  - When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 8.1: We will tell you in advance when your coverage will be ending

The agency or facility that is providing your care will give you a notice at least two days before we stop paying for your care.

- The written notice tells you the date when we will stop covering your care.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does not mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying.

AT A GLANCE: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization in your state and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

Section 8.2: Level 1 Appeal to continue your care

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start, understand what you need to do and what the deadlines are.

- Meet the deadlines. The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- Ask for help if you need it. If you have questions or need help at any time, please call Member Services at 1-877-723-7702 (TTY/TDD: 711). Or call the Senior HelpLine at 1-800-252-8966, TTY: 1-888-206-1327.

During a Level 1 Appeal, The Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the Notice of Medicare Non-Coverage.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for an independent review of whether it is medically appropriate for us to end coverage for your services.
What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4 (page 115).

The legal term for the written notice is “Notice of Medicare Non-Coverage.”

To get a sample copy, call Member Services at 1-877-723-7702 (TTY/TDD 711) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven (7) days a week. TTY users should call 1-877-486-2048.). Or, see a copy online at http://www.cms.hhs.gov/BNI/.

What happens during the Quality Improvement Organization’s review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- Within one full day after reviewers have all the information they need, they will tell you their decision. You will get a letter explaining the decision.

The legal term for the letter explaining why your services should end is “Detailed Explanation of Non-Coverage.”

What happens if the reviewers say Yes?

- If the reviewers say Yes to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say No to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends, then you will have to pay the full cost of this care yourself.

Section 8.3: Level 2 Appeal to continue your care

If the Quality Improvement Organization said No to the appeal and you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

You can ask the Quality Improvement Organization to take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end. The Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the Notice of Medicare Non-Coverage.

AT A GLANCE: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization in your state and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.
Chapter 9: What to do if you have a problem or complaint (Coverage Decisions, Appeals, Complaints)

Ask for the Level 2 review within 60 days after the day when the Quality Improvement Organization said No to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 days.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a “fast review.”
- If we say Yes to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.

It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.

If we say No to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

- If you continue getting services after the day we said they would stop, you may have to pay the full cost of the services.
- To make sure we were following all the rules when we said No to your fast appeal, we will send your appeal to the “Independent Review Entity.” When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for “fast review” or “fast appeal” is “expedited appeal.”

AT A GLANCE: At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a “fast review.”

We will give you our decision within 72 hours.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 (page 117) of this chapter tells how to make a complaint.

During the Level 2 Appeal, the Independent Review Entity reviews the decision we made when we said No to your “fast review.” This organization decides whether the decision we made should be changed.

- The Independent Review Entity does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.
- The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal.
- If this organization says Yes to your appeal, then we must pay you back for our share of the costs of care. We must also continue the plan’s coverage of your services for as long as it is medically necessary.
- If this organization says No to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

The formal name for “Independent Review Organization” is “Independent Review Entity.” It is sometimes called the “IRE.”

For more information, visit www.bcbsilcommunitymmai.com.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Section 9.2: Next steps for Medicaid services

You also have more appeal rights if your appeal is about services that might be covered by Medicaid. After your Level 2 Appeal in the State Fair Hearings office has concluded, you will receive a written decision called a “Final Administrative Decision.” This decision is made by the Director of the Agency based on recommendations from the Impartial Hearing Officer. The decision will be sent to you and all interested parties in writing by the Hearings office. This decision is reviewable only through the Circuit courts of the State of Illinois. The time the Circuit Court will allow for filing for such review may be as short as 35 days from the date of your Final Administrative Decision.

Section 10: How to make a complaint

What kinds of problems should be complaints?

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Blue Cross Community MMAI staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about physical accessibility

- You cannot physically access the health care services and facilities in a doctor or provider’s office.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor’s office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

The legal term for a “complaint” is a “grievance.”

The legal term for “making a complaint” is “filing a grievance.”

AT A GLANCE: How to make a complaint

Call Member Services or send us a letter telling us about your complaint.

If your complaint is about quality of care, you have more choices. You can:

1. Make your complaint to the Quality Improvement Organization,
2. Make your complaint to Member Services and to the Quality Improvement Organization, or
3. Make your complaint to Medicare.

Section 10.1: Details and deadlines

- Call Member Services at 1-877-723-7702 (TTY/TDD: 711). If you are requesting action regarding a Medicare issue, the complaint must be made within 60 calendar days after you had the problem you want to complain about.
- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
  - If you send us the complaint in writing, please include the date and place the incident happened, the names of people involved and details about what happened. Be sure to include your name and member ID number.
  - During the complaint process, you may have someone you know act on your behalf. This person will be your “representative.” If you decide to have someone act for you, please let our Member Services know and they will help you.
  - We will let you know we received your formal complaint within three (3) business days after we receive it.
  - We will look into your complaint as quickly as possible and give you an answer in no later than 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days to answer your complaint.
After you get our answer about your complaint, if you are still not satisfied you may ask to have your concerns heard at a grievance committee.

- You must ask for this within 10 calendar days after you receive our answer.
- We will let you know we received your request within three (3) business days after we get it, and will let you know the date of the next committee hearing.
- The committee will review your complaint and we will send you a decision within 30 calendar days. The decision of the committee is final.

Some complaints, by their nature, cannot be resolved (for example: food at Adult Day Health was served cold). Our plan tracks and logs these complaints and looks to identify any repeated problems and uses this information to tell the proper department (for example: the Provider Network Management Department or the Clinical Department) about inferior care.

- If you are concerned about the quality of care you received, including care during a hospital stay, you may complain to Telligen, the Quality Improvement Organization for Illinois, by calling 1-800-386-6431.
- If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.

The legal term for “fast complaint” is “expedited grievance.”

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- Most complaints are answered in 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- If we do not agree with some or all of your complaint we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

Section 10.2: You can file complaints with the Office of Civil Rights

If you have a complaint about disability access or about language assistance, you can file a complaint with the Office of Civil Rights at the Department of Health and Human Services. The contact information is:

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Voice Phone (800) 368-1019
FAX (312) 886-1807
TDD (800) 537-7697

You may also have rights under the Americans with Disability Act. You can contact the Senior HelpLine for assistance. The phone number is 1-800-252-8966, TTY: 1-888-206-1327.
Section 10.3: You can make complaints about quality of care to the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us and also to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

The phone number for the Quality Improvement Organization is 1-800-647-8089.

Section 10.4: You can also tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.
Chapter 10: Ending your membership in our Medicare-Medicaid Plan

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If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Introduction

This chapter tells about ways you can end your membership in our plan and your health coverage options after you leave the plan. You will still qualify for both Medicare and Medicaid benefits if you leave our plan.

A. When can you end your membership in our Medicare-Medicaid plan?

You can request to end your membership in Blue Cross Community MMAI Medicare-Medicaid Plan at any time. If you want to go back to getting your Medicare and Medicaid services separately:

- Your membership will end on the last day of the month that we get your request to change your plan. Your new coverage will begin the first day of the next month. For example, if we get your request on January 18th, your new coverage will begin February 1st.

If you want to switch to a different Medicare-Medicaid Plan:

- If you request to change plans before the 12th of the month, your membership will end on the last day of that same month. Your new coverage will begin the first day of the next month. For example, if we get your request on August 6th, your coverage in the new plan will begin September 1st.
- If you request to change plans after the 12th of the month, your membership will end on the last day of the following month. Your new coverage will begin the first day of the month after that. For example, if we get your request on August 24th, your coverage in the new plan will begin October 1st.

For information on Medicare options when you leave our plan, see the table on page 4.

For information about your Medicaid services when you leave our plan, see page 5.

These are ways you can get more information about when you can end your membership:

- Call Illinois Client Enrollment Services at 1-877-912-8880, from 8 a.m. to 7 p.m. Monday through Friday and 9 a.m. to 3 p.m. on Saturday. TTY users should call 1-866-565-8576.
- Call the Senior Health Insurance Program (SHIP) at 1-800-548-9034. TTY users should call 1-866-323-5321.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
Chapter 10: Ending your membership in our Medicare-Medicaid plan

B. How do you end your membership in our plan?

If you decide to end your membership, tell Medicaid or Medicare that you want to leave Blue Cross Community MMAI:

- Call Illinois Client Enrollment Services at 1-877-912-8880, from 8 a.m. to 7 p.m. Monday through Friday and 9 a.m. to 3 p.m. on Saturday. TTY users should call 1-866-565-8576; OR
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 4.

C. How do you join a different Medicare-Medicaid plan?

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different Medicare-Medicaid plan.

To enroll in a different Medicare-Medicaid plan:

- Call Illinois Client Enrollment Services at 1-877-912-8880, from 8 a.m. to 7 p.m. Monday through Friday and 9 a.m. to 3 p.m. on Saturday. TTY users should call 1-866-565-8576. Tell them you want to leave Blue Cross Community MMAI and join a different Medicare-Medicaid plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

If we get your request before the 12th of the month, your coverage with Blue Cross Community MMAI will end on the last day of that same month. If we get your request after the 12th of the month, your coverage with Blue Cross Community MMAI will end on the last day of the following month. See Section A above for more information about when you can end your membership.
D. If you leave our plan and you do not want a different Medicare-Medicaid plan, how do you get Medicare and Medicaid services?

If you do not want to enroll in a different Medicare-Medicaid plan after you leave Blue Cross Community MMAI, you will go back to getting your Medicare and Medicaid services separately.

How you will get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

1. You can change to:
   A Medicare health plan, such as a Medicare Advantage plan or Programs of All-inclusive Care for the Elderly (PACE)

   Here is what to do:
   Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven (7) days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan.
   If you need help or more information:
   Call the Senior Health Insurance Program (SHIP) at 1-800-548-9034.
   You will automatically be disenrolled from Blue Cross Community MMAI when your new plan’s coverage begins.

2. You can change to:
   Original Medicare with a separate Medicare prescription drug plan

   Here is what to do:
   Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven (7) days a week. TTY users should call 1-877-486-2048.
   If you need help or more information:
   Call the Senior Health Insurance Program (SHIP) at 1-800-548-9034.
   You will automatically be disenrolled from Blue Cross Community MMAI when your new plan’s coverage begins.

3. You can change to:
   Original Medicare without a separate Medicare prescription drug plan

   NOTE: 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 tell Medicare you don’t want to join.
   You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call your Senior Health Insurance Program at 1-800-548-9034.

   Here is what to do:
   Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven (7) days a week. TTY users should call 1-877-486-2048.
   If you need help or more information:
   Call the Senior Health Insurance Program (SHIP) at 1-800-548-9034.
   You will automatically be disenrolled from Blue Cross Community MMAI when your Original Medicare coverage begins.
How you will get Medicaid services

If you leave the Medicare-Medicaid plan, you will either get your Medicaid services through fee-for-service or remain in our plan to get your Medicaid services.

If you are in a nursing facility or are enrolled in a Home and Community Based Service (HCBS) waiver, you will remain in our plan to get your Medicaid services.

- You will have 90 days to switch to another Medicaid-only health plan.
- You will get a new member ID card, a new Member Handbook, and a new Provider and Pharmacy Directory.

If you are not in a nursing facility or enrolled in a HCBS waiver, you will be in Medicaid fee-for-service. This is how you received your Medicaid services before joining our plan. You can see any provider that accepts Medicaid and new patients.

E. Until your membership ends, you will keep getting your medical services and drugs through our plan

If you leave Blue Cross Community MMAI, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. See page 6 for more information. During this time, you will keep getting your health care and drugs through our plan.

- You should use our network pharmacies to get your prescriptions filled. Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.
- 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. This will happen even if your new health coverage begins before you are discharged.

F. Your membership will end in certain situations

These are the cases when Blue Cross Community MMAI must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan’s service area.
- If you go to prison.
- If you lie about or withhold information about other insurance you have for prescription drugs.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your ID card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
G. We cannot ask you to leave our plan for any reason related to your health

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, seven days a week. You should also call Medicaid’s Health Benefits Hotline at 1-800-226-0768. TTY users should call 1-877-204-1012.

H. You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also see Chapter 9 Section 10, page 117, for information about how to make a complaint.

I. Where can you get more information about ending your plan membership?

If you have questions or would like more information on when we can end your membership, you can call Member Services at 1-877-723-7702 (TTY/TDD: 711). We are open:

- October 1 to February 14: 8 a.m. to 8 p.m., Central time, seven days a week
- February 15 to September 30: 8 a.m. to 8 p.m., Central time, Monday through Friday
Chapter 11: Legal notices

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If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
A. Notice about laws

Many laws apply to this Member Handbook. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, religion, or sex. If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information.

C. Notice about Blue Cross Community MMAI as a Second Payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

Blue Cross Community MMAI has the right and the responsibility to collect payment for covered services when someone else has to pay first.

Blue Cross Community MMAI’s Right of Subrogation

Subrogation is the process by which Blue Cross Community MMAI gets back some or all of the costs of your health care from another insurer. Examples of other insurers include:

• Your motor vehicle or homeowner’s insurance
• The motor vehicle or homeowner’s insurance of an individual who caused your illness or injury
• Workers’ Compensation

If an insurer other than Blue Cross Community MMAI should pay for services related to an illness or injury, Blue Cross Community MMAI has the right to ask that insurer to repay us. Unless otherwise required by law, coverage under this policy by Blue Cross Community MMAI will be secondary when another plan, including another insurance plan, provides you with coverage for health care services.

Blue Cross Community MMAI’s Right of Reimbursement

If you get money from a lawsuit or settlement for an illness or injury, Blue Cross Community MMAI has a right to ask you to repay the cost of covered services that we paid for. We cannot make you repay us more than the amount of money you got from the lawsuit or settlement.

Your Responsibilities

As a member of Blue Cross Community MMAI, you agree to:

• Let us know of any events that may affect Blue Cross Community MMAI’s rights of Subrogation or Reimbursement.
• Cooperate with Blue Cross Community MMAI when we ask for information and assistance with Coordination of Benefits, Subrogation, or Reimbursement.
• Sign documents to help Blue Cross Community MMAI with its rights to Subrogation and Reimbursement.
• Authorize Blue Cross Community MMAI to investigate, request and release information which is necessary to carry out Coordination of Benefits, Subrogation, and Reimbursement to the extent allowed by law.
• Pay all such amounts to Blue Cross Community MMAI recovered by lawsuit, settlement or otherwise from any third person or his or her insurer to the extent of the benefits provided under the coverage, up to the value of the benefits provided.

If you are not willing to help us, you may have to pay us back for our costs, including reasonable attorneys’ fees, in enforcing our rights under this plan.
D. Patient Confidentiality and Notice About Privacy Practices

We will ensure that all information, records, data and data elements related to you, used by our organization, employees, subcontractors and business associates, shall be protected from unauthorized disclosure pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 USC 654(26); 42 CFR Part 431, Subpart F; and 45 CFR Part 160 and 45 CFR Part 164, Subparts A and E.

We are required by law to provide you with a Notice that describes how health information about you may be used and disclosed, and how you can get this information. Please review this Notice of Privacy Practices carefully. If you have any questions, call Member Services at 1-877-723-7702 (TTY/TDD 711). We are open:

October 1 to February 14  February 15 to September 30
8 a.m. to 8 p.m., Central time  8 a.m. to 8 p.m., Central time
Seven days a week  Monday through Friday

To obtain a copy of the Notice of Privacy Practices, please call Member Services or visit the website at www.bcbsilcommunitymmai.com.
If you have questions, please call Blue Cross Community MMAI at 1-877-723-7702 (TTY/TDD 711), 8:00 a.m. until 8:00 p.m. Central time, seven (7) days a week (October 1 through February 14) and 8:00 a.m. until 8:00 p.m. Central time, Monday through Friday (February 15 through September 30). The call is free. For more information, visit www.bcbsilcommunitymmai.com.
Chapter 12: Definitions of important words

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about an appeal or fair hearing. This continued coverage is called “aid paid pending.”

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9, page 93, explains appeals, including how to make an appeal.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than the plan’s cost sharing amount for services. We do not allow providers to “balance bill” you. Because Blue Cross Community MMAI pays the entire cost for your services, you should not get any bills from providers. Call Member Services if you get any bills that you do not understand.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: A plan developed by you and your care coordinator that describes what medical, behavioral health, social and functional needs you have and identifies goals and services to address those needs.

Care team: A care team, lead by a care coordinator, may include doctors, nurses, counselors, or other professionals who are there to help you build a care plan and ensure you get the care you need.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2, Section G, page 16, explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9, Section 5.2, page 96, explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).
**Durable medical equipment:** Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

**Emergency:** A medical condition that a prudent layperson with an average knowledge of health and medicine, would expect is so serious that if it does not get immediate medical attention it could result in death, serious dysfunction of a body organ or part, or harm to the function of a body part, or, with respect to a pregnant woman, place her or her unborn child’s physical or mental health in serious jeopardy. Medical symptoms of an emergency include severe pain, difficulty breathing, or uncontrolled bleeding.

**Emergency care:** Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

**Exception:** Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

**Extra Help:** A Medicare program that helps people with limited incomes and resources pay for Medicare Part D prescription drugs. Extra help is also called the “Low-Income Subsidy,” or “LIS.”

**Fair hearing:** A chance for you to tell your problem in court and show that a decision we made is wrong.

**Generic drug:** A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

**Grievance:** A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

**Health plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.

**Health assessment:** A review of an enrollee’s medical history and current condition. It is used to figure out the patient’s health and how it might change in the future.

**Home health aide:** A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

**Hospice:** A program of care and support for people who are terminally ill to help them live comfortably. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs. An enrollee who has six months or less to live has the right to elect hospice. Blue Cross Community MMAI must give you a list of hospice providers in your geographic area.

**Inpatient:** A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

**List of Covered Drugs (Drug List):** A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary.”

**Long-term services and supports (LTSS):** Long-term services and supports include Long Term Care and Home and Community Based Service (HCBS) waivers. HCBS waivers can offer services that will help you stay in your home and community.

**Low-income subsidy (LIS):** See “Extra Help.”
**Chapter 12: Definitions of important words**

**Medicaid (or Medical Assistance):** A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section H, page 17, for information about how to contact Medicaid in your state.

**Medically necessary:** This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules.

**Medicare:** The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see “Health plan”).

**Medicare-covered services:** Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

**Medicare-Medicaid enrollee:** A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dual eligible beneficiary.”

**Medicare Part A:** The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

**Medicare Part B:** The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

**Medicare Part C:** The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

**Medicare Part D:** The Medicare prescription drug benefit program. (We call this program “Part D” for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. Blue Cross Community MMAI includes Medicare Part D.

**Medicare Part D drugs:** Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

**Member (member of our plan, or plan member):** A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

**Member Handbook and Disclosure Information:** This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected documents, which explains your coverage, what we must do, your rights, and what you must do as a member of our plan.

**Member Services:** A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2, Section A, page 9, for information about how to contact Member Services.

**Model of care:** An integrated approach with one Care Coordinator handling the member holistically. This includes disease management, case management, health and wellness and behavioral health.

**Network pharmacy:** A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.
Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services. We call them “network providers” when they agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman: An office in your state that helps you if you are having problems with our plan. The ombudsman’s services are free.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this handbook. Chapter 9, Section 4.2, page 93, explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare is available everywhere in the United States. If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3, Section D, page 23 explains out-of-network providers or facilities.

Part A: See “Medicare Part A.”

Part B: See “Medicare Part B.”

Part C: See “Medicare Part C.”

Part D: See “Medicare Part D.”

Part D drugs: See “Medicare Part D drugs.”

Primary care provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section D, page 23 for information about getting care from primary care providers.

Prior authorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4, Section D, page 35. Some drugs are covered only if you get prior authorization from us. Covered drugs that need prior authorization are marked in the List of Covered Drugs.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. See Chapter 2, Section F, page 15 for information about how to contact the QIO for your state.
Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription or how many refills you can get.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. See Chapter 4, Section D, page 35 to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. The plan may drop you if you move out of the plan’s service area.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.


Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.
Contact Information

Blue Cross Community MMAI Member Services

Call
1-877-723-7702 (TTY/TDD 711)
October 1 through February 14
8 a.m. to 8 p.m., Central time
Seven days a week
February 15 through September 30
8 a.m. to 8 p.m., Central time
Monday through Friday

Alternate technologies (for example, voice mail) will be used on the weekends and Federal holidays. The call is free.

Web
www.bcbsilcommunitymmai.com
Medicare-Medicaid Plan provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent licensee of the Blue Cross and Blue Shield Association. HCSC is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees. Enrollment in HCSC’s plan depends on contract renewal.