THANK YOU FOR BECOMING A MEMBER OF THE BLUE CROSS COMMUNITY FAMILY HEALTH PLANSM (THE PLAN) FROM BLUE CROSS AND BLUE SHIELD OF ILLINOIS.

This handbook will help you get the most from your Plan:

- How to use providers in the Plan network
- Important phone numbers to know
- How the Plan works
- What the Plan covers and what it does not cover
- When you will need our approval (OK) for services (prior authorization)

This handbook also explains:

- Health information privacy
- Grievances and appeals
- Member Rights and Responsibilities

WHEN YOU NEED TO CONTACT MEMBER SERVICES
Our goal is to serve your health care needs through all of life’s changes. If you have any questions, our team stands ready to help.

CALL 1-877-860-2837 • TTY/TDD 711
We are open:

October 1 to February 14
8 a.m. to 8 p.m., Central time
Seven (7) 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 federal holidays. The call is free.

WEBSITE www.bcbsilcommunityfamilyhealthplan.com
WRITE Blue Cross Community Family Health Plan • P.O. Box 3418 • Scranton, PA 18505

YOUR MEMBER ID CARD HAS ALREADY BEEN MAILED TO YOU.
Your member ID card has already been sent to you. If you do not receive it within two weeks please call Member Services. Please have your ID card in-hand when you need care.

Help In Other Languages
Call Member Services if you want help in another language. The Plan offers interpreter services. Please see page 3 for more details.

Help For Members With Hearing or Vision Loss
The Plan has a toll-free number for members with hearing or speech loss. Call the Member Services TTY/TDD line during normal business hours. Members with hearing or vision loss can get this handbook and important Plan details in other formats.

Member Services: 1-877-860-2837 • TTY/TDD 711 • www.bcbsilcommunityfamilyhealthplan.com
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HOW TO USE THIS BOOK
You will find this handbook easy to use. Here are some tips to help you get started and save time:

READ THESE PARTS FIRST:
• Important Things to Do
• How to use your Blue Cross Community Family Health Plan
• Emergency and Urgent Care Services

THEN READ:
• What is covered
• What is not covered
• How to fill your prescriptions

ALSO READ:
• Other Things You May Need to Know
• Additional Resources, including the Appeals Process
• Your Health Care Rights and Responsibilities
• Important Phone Numbers

If you need help with this handbook, call Member Services. The number is at the bottom of each page.

IMPORTANT THINGS TO DO
Keep your Blue Cross Community Family Health Plan ID card with you at all times, along with your Illinois Department of Healthcare and Family Services (HFS) medical card. Show it every time you need health care services. Do not let anyone else use your card.

Make sure the doctor on your ID card is the one you want. Your ID card lists your Primary Care Provider (PCP). This doctor is your main health care provider. If you want a different PCP, let us know right away.

Make sure you use providers in the Plan network. If no one in the network can give you the care you need, your PCP may ask us for an OK to send you to a provider that is not in the Plan network. If you do not have a health care emergency, you should use a provider in the network.

Set up an initial health exam with your PCP right away.
• If you are an adult, your first health exam needs to be within 90 days of joining the Plan.
• A child should be seen by a doctor within 90 days of joining the Plan.
• A newborn should be seen by a doctor within 14 days after birth.

During the first exam, the PCP will learn about your health care needs to help you stay healthy. Call Member Services if you need a ride to and from non-emergency medical visits.

If you have an emergency, get help right away. Call 911 or go to the nearest emergency room (ER) for medical care. Call an ambulance if there is no 911 service in your area. You do not need an approval from the Plan or your PCP for emergency care. It does not matter if you are inside or outside the network service area. You will be covered for emergency services in the U.S. even if the provider is not part of the Plan.

If you have a health problem, you can talk to a nurse at the 24/7 Nurseline. The phone number is at the bottom of each page in this handbook. Have your ID card ready when you call.
HELP IN OTHER LANGUAGES

Can someone talk to me in my language about my health care?
The Plan offers interpreter services for many languages, and includes:

• Health education materials in English and Spanish, and in other languages if you ask
• People who can talk to you in your language
• Phone interpreter services
• Sign language and face-to-face interpreters
• Providers who speak two languages

How can I get a face-to-face interpreter in my provider’s office?
If you need help in a language other than English (that your PCP does not speak) during your medical visit, you can ask for a face-to-face or phone interpreter at no charge. The Plan’s Provider Directory tells you what languages the providers speak.

Who do I call for an interpreter?
Call Member Services and we will get someone who speaks your language.

How far in advance do I need to call?
If you need someone to translate for you while you are at your PCP’s office, call us at least 72 hours (three [3] business days) ahead of time. We will be glad to help and you do not have to use a family member or friend to translate for you unless that is your choice.

YOUR ID CARD

HOW TO READ IT, HOW TO USE IT
Show your ID card to your doctor, hospital or other provider when you go for health care services.

YOUR CARD HAS THESE IMPORTANT DETAILS ABOUT YOU:

• Name
• Member ID number
• Medicaid ID number
• Effective date of coverage
• Member Services phone number and TTY line
• PCP’s name and phone number
• Blue Cross Community Family Health Plan name and claims address
• The toll-free number for the 24/7 Nurseline

YOU WILL GET A NEW PLAN ID CARD IF:

• You change your PCP
• Your PCP’s address or phone number changes
• You lose your ID card

Call Member Services to replace your ID card if it is lost.
GET A PRIMARY CARE PROVIDER (PCP) OR WOMEN’S HEALTH CARE PROVIDER (WHCP)

Your ID card will have the name and phone number of the PCP you chose, or the PCP assigned to you if you did not choose one. You can choose a different PCP for each family member.

Your PCP or Women’s Health Care Provider (WHCP) is your main health care provider. They also recommend you see special doctors (specialists) when needed. You can see a Blue Cross and Blue Shield of Illinois® specialist without a referral from your PCP, but it is important that your PCP knows which doctors you see.

A PCP CAN BE A:

- Pediatrician
- Family or general practitioner
- Obstetrician/Gynecologist (OB/GYN)
- Internist (Internal Medicine)
- Nurse Practitioner (NP) or Physician Assistant (PA)
- A clinic such as Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) can also be PCPs

TO DO:

You must choose a PCP from the Blue Cross Community Family Health Plan Provider Network. Look in the Provider Directory to:

- Choose a PCP for your child under Family Practice, Pediatrics or General Practice
- Choose a PCP for a pregnant member under OB/GYN, Family Practice, Internal Medicine or General Practice
- Choose a PCP for adults in your family under Family Practice, Internal Medicine or General Practice. Women may also choose an OB/GYN as a PCP

You can call Member Services for help choosing a PCP. You can also ask Member Services to mail you a Provider Directory. The website also has an online directory and a tool called Provider Finder®.

You can reach your PCP 24 hours a day at the PCP number on your ID card. After regular business hours, leave your name and phone number with the answering service. Either your PCP or an on-call doctor will call you back. If you have an emergency, call 911 or go to the nearest ER. You can also call the 24/7 Nurseline.

Can I choose any WHCP as my PCP?
A woman can go to a WHCP as her PCP, but the WHCP must be an in-network provider and accepting new patients.

Can I stay with my WHCP if he or she is not in with the Plan? Will I need prior authorization?
The WHCP must be part of the Family Health Plan network. No prior authorization is needed to see a WHCP.

How do I choose a WHCP or PCP?
Look in the Provider Directory for PCPs and WHCPs who work with the Family Health Plan and who are taking new patients.
Call Member Services or visit the website to get the most up-to-date information about the network.
PROVIDER DIRECTORY

You may view the Provider Directory online or in print. Go to www.bcbsil.com/fhp and click ‘Provider Finder.’ Then search by ‘Provider Type,’ ‘Provider Name’ and ‘Location’ to find a doctor. Call Member Services if you want a printed copy of the directory or need help.

It is important to find the right PCP. The Provider Directory answers such questions as:

- What language does the PCP speak?
- Is the PCP’s office open on weekends?
- Is the PCP a man or a woman?

CHANGING YOUR PCP

How can I change my PCP?
Call Member Services to change your PCP. Unless a change is truly needed, it is best to keep the same PCP so he or she can get to know your health needs and history.

If you do change your PCP, be sure to have your medical records sent to the new PCP.

How many times can I change my PCP?
There is not a limit on how many times you can change a PCP.

What are the reasons a request to change a PCP may be denied?
- The PCP is not taking new patients
- The PCP is not in your network
- The PCP is outside your service area

When will my PCP change be made?
- Within 30 days of getting your request for the change
- You will get a new ID card with your PCP’s name and contact details on it

What if I choose to go to a doctor who is not my PCP?
You may have to pay for services by a doctor who is not in the Community Family Health Plan network.

MAKE AN APPOINTMENT WITH YOUR DOCTOR

Call your PCP for an appointment. Tell him or her you are a Community Family Health Plan member. Have your ID card with you when you call.

When going to your doctor’s appointment:
- Take your Plan ID card and HFS medical card with you
- Be on time for your appointment
- Call the doctor’s office as soon as possible if you are going to be late or need to cancel.

Keep in mind, your PCP may not be able to see you if you are late.

What if I need to cancel an appointment?
Call your PCP’s office and someone will help you set up a new appointment.

INITIAL HEALTH EXAM

The first meeting with your new PCP is important. It is a time for you to get to know each other and talk about your health. Your PCP will:
- Take your medical history
- Give you a physical exam
- Provide you with health information
- Assess your health care needs

We ask all new members 21 years and older to see their PCP within 90 days after joining the Family Health Plan. Members under the age of 21 should also see their PCP within 90 days of joining the Plan. Newborns should see their PCP within 14 days of joining the Plan.

ROUTINE MEDICAL CARE

Routine medical care is the regular care you get from your PCP to help keep you healthy. You should be able to see your PCP within 14 days from the date you call to make your appointment.
URGENT MEDICAL CARE

**What is urgent medical care?**

An urgent medical condition is not an emergency, but medical care is needed within 24 hours. Call your PCP if you have an urgent medical condition. If you cannot reach your PCP:

- Call Member Services
- Call the 24/7 Nurseline

**How soon can I expect to be seen?**

*SPECIALTY CARE*

**What if I need to see a special doctor (specialist)?**
Your PCP may send you to a different doctor for special care or treatment. Someone at the PCP’s office can help you make the appointment.

You do not need a referral from your PCP to see a specialist who is an in-network provider. You do need to let your PCP know if you have seen a specialist. Your PCP can take better care of you if he or she knows about the specialists you see.

**How soon can I expect to be seen by a specialist?**
You will get your appointment within 30 days of the request. Out-of-network services are not covered unless you get an OK from us before you get the service.

SCHOOL-BASED HEALTH CENTERS

School-based Health Centers offer health care services at the child’s school or near the child’s school. Most medical, dental, and behavioral services provided by a school-based health center are covered by the plan. Your child does not need an OK from us for care provided by these centers. Please call Member Services at **1-877-860-2837**, (TTY/TDD **711**) if you have questions or need assistance.

CARE COORDINATION

As a Plan member, you can get care coordination support. Within 60 days of joining the Plan, we will call and ask you some health related questions. This Health Risk Assessment (HRA) will be done at least once a year after that.

The HRA helps us find the level of care coordination support you may need and it could mean we provide you with a Care Coordinator. A Care Coordinator will work with you and others involved in your care, like your PCP, to help with your health care needs. These resources are called an Interdisciplinary Care Team. They work with you to find out what your needs are and make a Care Plan that helps you reach your health care goals.

Care Coordinators also do these things:

- Plan in-person visits or phone calls with you
- Listen to your concerns
- Help get you or your family the services you need, like transportation
- Help set up care with doctors and other health care team members
- Help you, your family and your caregiver better understand your health condition(s), medications, and treatments
GETTING A SECOND MEDICAL OPINION

How can I ask for a second opinion?

You may have questions about care your PCP or doctor says you need. You may want a second opinion to:

- Diagnose an illness
- Make sure your treatment plan is right for you

You should speak to your PCP if you want a second opinion. He or she will send you to a doctor who:

- Also works with the Plan
- Is the same kind of doctor you saw first

You may get an OK from the Plan to see a doctor who is not with the Plan.

Call Member Services for help getting a second opinion or call your Care Coordinator.

SERVICE AREA

The plan covers members who live in these counties: Cook, DuPage, Kane, Kankakee, Lake and Will.

What if I am traveling?

If you get sick in some other county or state, the Plan will only pay for emergency services. We cover emergencies anywhere in the United States. The Plan does not cover services outside the United States.

If you have an emergency while you are away from home:

- Go to the nearest hospital
- Show them your member ID card
- Do not make a payment
- All charges should be billed to the Plan

You may have to pay if you get care outside your service area if it is not an emergency and you do not have an OK from us.
PRIOR AUTHORIZATION (AN OK FROM BLUE CROSS COMMUNITY FAMILY HEALTH PLAN)

Your PCP will get an OK from the Plan for some services to make sure they are covered. This means that both the Plan and your PCP (or specialist) agree that the services are medically necessary. “Medically necessary” refers to services that:

- Protect life
- Keep you from getting seriously ill or disabled
- Reduce severe pain by finding out what is wrong or treating the disease, illness or injury

Getting an OK takes no more than 10 days in most cases, or if needed faster, no more than three (3) business days. To check service limits, see the section called “What is Covered by Blue Cross Community Family Health Plan.” Your PCP can also tell you more about this.

We may ask your PCP why you need special care and we may not always OK requested services. If that happens, we will send you and your PCP a letter stating why the service will not be covered. The letter will tell you how to appeal our decision if you disagree.

We will not pay for services from a provider that is not part of the Plan network if you did not get an OK from us before getting the services.

Some services that require a prior authorization (an OK from your PCP):

- All inpatient facility admissions require Plan approval
- Selected behavioral health procedures and services
- Inpatient surgical procedures
- Selected outpatient surgical procedures
- High dollar radiology
- Selected durable medical equipment (DME), medical supply and prosthetic/orthotic services
- Home health care
- Outpatient therapies
- Select specialty and infusion medications
- Transportation services (call MTM at 1-844-549-8348)
- Some vision services
- Some dental services
- Services from an out of plan provider

What services do not need an authorization (or OK from my PCP)?

- Primary care
- Family planning
- WHCP Services (you must choose doctors in the network)
- In-network specialists
- Emergency care
- Well-child Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) care
- Well-baby care
DEDUCTIBLES AND COPAYS
You do not have to pay any deductibles or copays for approved services.

What if I get a bill from my doctor?
In most cases, you should not get a bill from a Plan provider. You may have to pay for charges if:

• You agree to pay for services that are not covered or OK’d by the Plan
• You agree to pay for services from a provider who does not work with the Plan and you did not get an OK from us ahead of time

Who do I call?
Call Member Services if you get a bill and do not think you should have.

MAKING CHANGES TO YOUR PLAN

What should I do if I move?
Call Member Services for your next steps as soon as you have your new address.

Can I change health plans?
If you are new to the Plan, you will have 90 days from the date of your first enrollment to try it. Clients can only change one (1) time during the first 90 days.

• During the first 90 days, if you want to change plans for any reason, call the Illinois Client Enrollment Services (ICES) at 1-877-912-8880 (TTY/TDD 1-866-565-8576)
• After 90 days, if you are still eligible, you will stay enrolled in (“locked into”) the current Plan for the next nine months.

At the end of your enrollment year, you will get a letter from ICES. The letter will tell you about “open enrollment,” the time when you can change health plans if you would like. You will have 60 days to make a change. You can change health plans during open enrollment every year.

If you change plans, you will be a member in your chosen new plan at the end of your current enrollment year. Whether you pick a new plan or stay with the current Plan, you will be locked into that plan for the next 12 months.

DIS-ENROLL FROM (DROP OUT OF) THE PLAN
Reasons you may request to drop out of the Plan at any time include, but are not limited to:

• Moving out of the service area
• The Plan is not covering services you need
• Related covered services needed at the same time are not available through the Plan, and your PCP or other doctor believes getting the services separately would risk your health
• Poor quality of care
• Lack of access to providers who treat your health care needs

What happens if I lost my Medicaid coverage
If you lost Medicaid eligibility for 60 days or less and then become eligible again, you will be re-enrolled with the Plan. We will reassign you to your past PCP if that PCP is still accepting patients.
EMERGENCY AND URGENT CARE SERVICES

IF YOU HAVE A TRUE EMERGENCY, CALL 911 OR GO TO THE NEAREST ER

Emergency services are covered even if the provider is not part of the Plan network.

An Emergency Medical Condition is a recent condition or serious injury with severe symptoms that without immediate medical care could result in:

- Serious danger to the patient’s health
- Serious damage to bodily functions including organs
- Disfigurement
- In the case of a pregnant woman, threat to the health of the woman or her unborn child

CALL 911 OR GO TO THE ER IF A PERSON:

- Has chest pains
- Cannot breathe or is choking
- Has passed out or is having a seizure
- Is sick from poison or a drug overdose
- Has a broken bone
- Is bleeding a lot
- Has been attacked
- Is about to deliver a baby
- Has a serious injury to the arm, leg, hand, foot or head
- Has a severe burn
- Has a severe allergic reaction
- Has an animal bite
- Has trouble controlling behavior and, without treatment, is dangerous to himself or herself or others

Do not use the ER for routine care. If you do, you may have to pay for those services. We do not cover ER visits for routine care.

How soon can I expect to be seen?

You will be seen as soon as possible.

When should I call my PCP or Care Coordinator?

You should call your PCP after any emergency (at home or away) so your doctor can plan your follow-up care. If you have a Care Coordinator, you must also call him or her after an emergency. Your Care Coordinator needs to know an emergency has occurred to make sure you get all the care and benefits you may be eligible to receive. You should call within 24 hours of leaving the ER.

Call 911 if you need emergency transport. You do not need an approval from the Plan for this service.

What if I get sick when I am traveling?

Call Member Services using the number on your ID card and we will help you find a doctor. If you need emergency care, go to a nearby hospital, then call Member Services. Emergency care is covered anywhere in the United States.

What if I am outside the United States?

Medical services performed out of the U.S. are not covered by Medicaid.

WHAT TO DO WHEN YOU NEED URGENT CARE

What is Urgent Care?

An urgent medical condition is not an emergency, but it may need medical care within 24 hours. This is not the same as a true emergency. You should call your PCP.

Examples of an urgent medical condition are:

- Sore throat
- Cold or flu
- Headache
- Sprained ankle

What if I cannot reach my PCP?

Call Member Services or the 24/7 Nurseline.

If you are away from home and need urgent care, call one of these right away:

- Your PCP
- Member Services
- 24/7 Nurseline
MATERNITY CARE

Call us when you know you are pregnant. Our staff will make sure that your OB/GYN and the hospital where you will have the baby are both in the Plan. We will enroll you in a prenatal program to help you learn how to take care of yourself while you are pregnant.

When should I get an appointment with my OB/GYN?

You need to set up your first prenatal care visit as follows:

- Within 14 calendar days from the date you call if you are in your first three months of pregnancy
- Within seven (7) calendar days from the date you call if you are in the second three months of pregnancy
- Within five (5) business days of the date you call if you are in the last three months of pregnancy

Call your OB/GYN and ask to set up an appointment within five business days, or right away, if you have an emergency. Also, call your OB/GYN if you think you have a high-risk condition that has to do with your pregnancy.

Join Special Beginnings®, our maternity program. Special Beginnings is there for you whenever you need it during your pregnancy and after your baby is born. When you join, you get a personal Special Beginnings nurse to answer your questions and talk with you about your pregnancy.

You will also get information and materials on nutrition and healthy life choices before and after your baby is born, and on how your unborn baby is growing.

Call Member Services as soon as you know you are pregnant to sign up for Special Beginnings.

ENROLLING A NEWBORN BABY

How do I sign up my newborn baby?

To make sure your baby has coverage, it is very important for you to call your Department of Human Services (DHS) Caseworker as soon as your baby is born. Your Special Beginnings Care Coordinator will remind you of this and can assist with connecting you to your DHS Caseworker if you need help.

Can I pick a PCP for my baby before the baby is born?

If you have not already called us to choose a PCP for your baby, you can call after the baby is born. Call Member Services to choose your baby’s PCP.

How and when can I switch my baby’s PCP?

Most of the time, it is best to keep the same PCP so he or she can get to know your baby’s health needs and history. You may find out later that you need to change PCPs, and if you need to do so, call Member Services.

You can change your baby’s PCP at any time as long as your baby is not in the hospital. You must choose a PCP who will see new patients. We can help you find one. If you choose a new PCP for your baby, have the medical records sent to the new PCP. You will get a new ID card with the new PCP’s name and contact details on it.

Can I switch my baby’s health plan?

For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up. Call Member Services for help.
WHAT IS COVERED BY BLUE CROSS COMMUNITY FAMILY HEALTH PLAN?

The Plan provides medical services for its members. All services must be medically necessary to be covered. Medically necessary means that services or supplies are needed to find or treat your medical condition. They must meet acceptable medical standards. We will not pay for services that are not medically necessary.

ANNUAL ADULT WELL EXAMS

Annual adult well exams are done by your PCP or WHPC. A physical exam may include:

- Height, weight and blood pressure checks
- Health screenings, such as diabetes, cholesterol, osteoporosis, tuberculosis or sexually transmitted diseases (STDs)
- Vaccines like influenza, tetanus, varicella, HPV, Singles or hepatitis A and B

The exam may also include a talk about:

- Family counseling
- Nutrition
- Exercise
- Substance abuse
- Sexual practices
- Injury prevention

AUDIOLOGY (HEARING) SERVICES

Assistive/augmentative communication (AAC) devices are covered.

Audiology services are covered for basic and advanced hearing tests. Hearing aids are covered when medically necessary, and require prior authorization. Hearing aids are limited to one (1) hearing aid per ear every three (3) years.
BEHAVIORAL HEALTH (MENTAL HEALTH / SUBSTANCE ABUSE) SERVICES
You do not need an OK from your PCP to get behavioral health services. Call 1-877-860-2837 (TTY/TDD 711) and someone will help you. Some of the behavioral health services we cover are:

• Mental health assessment and/or psychological evaluation
• Medication management
• Therapy/counseling (individual, family, group)
• Community treatment and support (individual, family, group)
• Long-term residential care
• Case Management services
• Intensive outpatient programs
• Outpatient Behavioral Health services
• Crisis Intervention and screening

Please see more on Substance Abuse on page 20.
If you see a provider in the network, you do not need a referral. Services may need an OK ahead of time so call Member Services to check if you are not sure.

CHIROPRACTOR SERVICES
Chiropractors help keep the spine or other body structures straight. Covered services include spinal manipulation and outpatient services to treat an illness or injury. You do not need an OK from your PCP to see an in-network chiropractor.

COLORECTAL CANCER SCREENING
Colorectal cancer screenings are covered.
DENTAL SERVICES
Dental providers take care of your teeth. You do not need an OK from your PCP for dental care. Visit our website to find a dental provider, or call Member Services.

Services include:

- Oral exams and X-rays
- Teeth cleanings (for adults age 21 and over, see Added Benefits on page 24)
- Fluoride treatments (for members up to age 21, one [1] per year)
- Sealants
- Fillings
- Crowns
- Root canals
- Dentures
- Extractions

Some limits apply to dental services. Call Member Services for details.

For members with special needs, we also cover practice visits to the dentist.

Services that are not covered include:

- Cosmetic dentistry
- Tooth bleaching or whitening
- Implants

Emergency dental services
The plan covers limited emergency dental services for the following:

- Dislocated jaw
- Traumatic damage to teeth and supporting structures
- Removal of cysts
- Treatment of oral abscess of tooth or gum origin
- Treatment and devices for craniofacial anomalies
- Drugs for any of the above conditions
DIAGNOSTIC AND THERAPEUTIC RADIOLOGY

Some radiology services need an OK from us before you get the service. Services include:

- X-rays and testing that are done to find out what is wrong, and are ordered and done by (or under the guidance of) your provider.
- Screening mammograms are covered at age 40. You may get one baseline mammogram after you turn 35.
- CT scans and MRIs, if medically necessary and OK’d by your PCP and us.

DOCTOR SERVICES

Covered services include:

- Visits to your PCP, WHCP, in-network specialist, or other in-network providers.
- Routine physicals for children from birth through age 20 (called Early and Periodic Screening, Diagnostic and Treatment checkups, or EPSDT).
- Yearly adult well exams.

DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES

These items are:

- Covered when medically necessary.
- Given for use in the home when medically necessary.

Most DME needs an OK from us ahead of time.

EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SERVICES (EPSDT OR WELL-CHILD CARE)

Well-child visits include:

- Medical checkups
- A general physical exam and assessment of your child’s growth and development
- An assessment of your child’s mental / behavioral health
- An assessment of your child’s nutrition
- Lab tests, including testing for lead
- Vaccines when due
- Vision and hearing screening
- Referrals for other medically necessary services

You do not need an OK from us to receive these services.
EMERGENCY AND URGENT CARE SERVICES

If you have a true emergency, call 911 or go to the nearest ER. You do not need an OK for emergency or urgent care services including transportation. Read more on page 10. Call your PCP for follow up care within two (2) days of your emergency, or as soon as you can. You must also call Member Services and let the Plan know you received services. Post stabilization services after an emergency are covered.

FAMILY PLANNING SERVICES

Some members want to start a family. If you do, you need to know how to be as healthy as you can before you become pregnant. Some members want to know how to avoid getting pregnant. Some members may need to know how to protect against diseases.

Covered family planning services include:

- Medical visits for birth control
- Marriage and family planning, education and counseling
- Birth control
- Pregnancy tests
- Lab tests
- Tests for sexually transmitted diseases (STDs)
- Sterilization

You do not need an OK from your PCP to get family planning help. Members may use any qualified family planning clinic, certified nurse midwife or provider. The provider does not need to be part of the Plan network. The Provider Directory can help.

Some services are not covered:

- Surgery to reverse sterilization
- Fertility treatments including artificial insemination or in vitro fertilization

You can find family planning providers near you on our website, or call Member Services for help.
HOME HEALTH CARE SERVICES
Home health care services need an OK from us. Some services are covered for your home when they are medically necessary. They include:

- Home health aide services
- Speech therapy
- Physical therapy visits
- Occupational therapy visits
- Durable Medical Equipment (DME)
- Medical supplies that are thrown away after use

HOSPICE SERVICES (INCLUDING PALLIATIVE)
For members who are not expected to live more than six (6) months, services include:

- Medical
- Social
- Support

HOSPITAL SERVICES
Your PCP can send you to any network hospital. Look in the Provider Directory to find a hospital. If it is an emergency, go to the nearest hospital Emergency Room (ER).

HOSPITAL - INPATIENT SERVICES
Inpatient hospital services need an OK from us. Covered services include:

- Rehab services in the hospital
- Surgery to remove the breast after a complete or partial removal of a breast for any medical reason
- Medical stabilization for chemical dependency in a general hospital
- A hospital room with two or more beds
- Care in special units
- Operating, delivery and special treatment rooms
- Supplies
- Medical testing
- Taking X-rays
- Drugs the hospital gives you during your stay (including oxygen)
- Giving you someone else's blood
- Radiation therapy
- Chemotherapy
- Dialysis treatment
- Meals and special diets
- General nursing care
- Anesthesia
- Respiratory therapy
- Diagnostic, therapeutic and rehabilitative services
- Staying in the hospital overnight for dental procedures because of other medical problems or serious dental work
- Coordination of discharge planning, including continuing ongoing care, if needed
- Detoxification

Private rooms are not covered unless medically necessary.
HOSPITAL - OUTPATIENT SERVICES
Some outpatient hospital services need an OK from us. Covered services include:

- Dialysis
- Emergency room use
- Birthing centers
- Physical, occupational or speech therapy
- Audiologists
- Drugs ordered by a doctor
- Giving you someone else’s blood
- Limited oral surgery
- Services to prevent or diagnose problems
- Therapeutic and rehabilitative services
- Surgery that does not need a hospital stay

LABORATORY AND X-RAY SERVICES
These services must be ordered by your provider and done by a licensed provider in an appropriate place. Covered services include:

- All medically necessary lab services
- Cancer tests
- X-ray services

MATERNITY CARE
Call Member Services as soon as you know you are pregnant. The following services are covered for maternity care:

- Prenatal evaluation and care
- Nutrition and exercise counseling
- Dental care
- Breastfeeding counseling
- Routine lab screenings
- Labor preparation
- Delivery
- Postpartum care and depression screening

Call your OB/GYN if you think you have a high-risk condition that has to do with your pregnancy. If you are pregnant sign up for Special Beginnings®, our prenatal program.

See more about Maternity Care on page 11.
**MEDICAL EQUIPMENT AND SUPPLIES**
Most need an OK from the Plan ahead of time. Covered supplies include:

- Prosthetics and orthotics
- Respiratory equipment and supplies
- Diabetic supplies

The Plan will cover costs within the limits of what is covered by Medicaid and when given for use in the home.

**Medical equipment and supplies are not covered if:**

- They are used for exercise
- They are still being tested or are research equipment
- More than one piece of equipment serves the same use
- They are used for making the room or home comfortable, such as:
  - Air conditioning
  - Air filters
  - Air purifiers
  - Spas/swimming pools
  - Elevators
- Supplies for hygiene or looks

**NON-EMERGENCY TRANSPORTATION SERVICES**
The Plan offers this service for medical needs, free of charge when you have no other way to get to:

- A doctor’s appointment
- An appointment with another health care provider
- A dental appointment
- A pharmacy after a provider visit

If you need a ride to the doctor, call Member Services for a ride at least three (3) days before the appointment. Call 911 for emergency transport only. (You do not need an OK from the Plan for emergency transport.) The hours of operation are Monday to Friday, 8 a.m. to 8 p.m. Central time. If you have a complaint about the service or staff, call Member Services to talk about your concerns.

**NURSING CARE SERVICES**
Covered for members under 21 not in the Home and Community Based Services (HCBS) Waiver and for individuals who are covered by the Medically Fragile Technology Dependent (MFTD) Waiver.

Nursing care also covers transitioning children from a hospital to home placement or other appropriate setting for members under 21.

These services need an OK from the Plan.

**NURSING FACILITIES SERVICES**
A Nursing Facility sometimes goes by a different name such as Nursing Home, Long-Term Care Facility or Skilled Nursing Facility. A Nursing Facility is a licensed facility that provides skilled nursing or long-term care after you have been in the hospital.

These services need an OK from the Plan.
ORTHOTICS AND PROSTHETICS
These services need an OK from us. They are covered services for all clients. Covered orthotics and prosthetics include:

- Medically necessary parts such as man-made arms and legs, and the parts that attach them.
- Orthotic braces, splints or ankle and foot supports when medically necessary.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY
These services need an OK from us. They are covered when they are ordered by a doctor and part of a written plan of care.

PODIATRY (FOOT CARE)
Members can get the following services covered:

- Medical problems of the feet.
- Medical or surgical treatment of disease, injury or defects of the feet.
- Cutting or removing corns, warts or calluses
- Routine foot care

For members under 21, additional services include:

- Treatment of flat feet
- Treatment of the feet when the bones are not in line and surgery is not needed

Limits
These services are not covered:

- Procedures that are still being tested
- Acupuncture
- Shoe inserts unless they are OK’d by the Plan (DME)
- Any service not listed as covered

PROSTATE AND RECTAL EXAMS
Prostate-specific antigen (PSA) and digital rectal exam (DRE) tests for men are covered for men age 40 and older.

SKIN CANCER SCREENING
Screenings for skin cancer are covered.

SUBSTANCE ABUSE
If you see a provider in the network, you do not need a referral; however you may need a prior authorization from us before you get services. Substance abuse treatments we cover include:

- Inpatient treatment
- Outpatient treatment
- Detoxification
- Day treatment
- Psychiatric evaluation services
- Admission and Discharge Assessment
- Intensive Outpatient
- Adolescent Residential Rehabilitation
- Medication Management

Please see also Behavioral Health on page 13.
TRANSPANTS
Transplants need an OK from us. When needed for medical reasons, we cover these transplants:

- Heart
- Lung
- Combined heart and lung
- Liver
- Kidney
- Cornea
- Stem cell

Limits
The first transplant is covered, but only one future re-transplant (because of rejection) is allowed.

VISION CARE SERVICES
Vision providers take care of your eyes. You do not need an OK from your PCP for vision care. Visit our website to find a vision provider, or call Member Services.

Services include:

- One (1) eye exam every 12 months per member
- Standard eye glasses
  - Every two (2) years for members 21 and older
  - Replaced ‘as needed’ for members under 21
- Contact lenses when medically necessary, if glasses cannot provide the intended result

If glasses or contacts are lost or stolen, contact Davis Vision at 1-888-715-6716. You can always call Member Services if you have any questions about what is and is not covered. We will pay only for those services we OK.
WELL-BABY CARE

Babies need to see their doctor many times in their first two years, even if they are not sick. At the well-baby checkups, your PCP will:

- Make sure your baby is growing the right way
- Give vaccines that will protect your baby from serious illness
- Find problems that may need special care
- Answer any questions you have about your baby

The first well-baby visit is in the hospital and the second is at two (2) weeks of age. After that, you should take your baby to the doctor for checkups and vaccines. When you want to choose a doctor for your new baby, call Member Services.

Set up appointments for well-baby visits at these ages:
- 1 Month
- 2 Month
- 4 Month
- 6 Month
- 9 Month
- 12 Month
- 15 Month
- 18 Month
- 24 Month

WOMEN’S HEALTH SERVICES

Includes services specific to women, family planning and reproductive health. Covered services include:

- Preventive services and screenings
- Medical history and reproductive health exam
- Family Planning services (see page 16)
- Mammogram screening
- Cervical cancer screening
- Supplements and prenatal vitamins
- Maternity care
- Prenatal care
- Delivery
- Postpartum care
- Nurse or Midwife services
- Hysterectomy
- Abortion (if the mother’s life is endangered, or to end a pregnancy caused by rape or incest)
WHAT IS NOT COVERED BY THE PLAN?

We will only pay for those services we OK. The following services are not covered by the Plan:

• Medical equipment and supplies that are:
  – Used only for your comfort or hygiene
  – Used for exercise
  – New or still being tested
  – More than one piece of equipment that does the same thing

• Supplies for hygiene or looks

• Care you got for health problems that have to do with work if they can be paid for by workers’ compensation, your employer, or by a disease law that has to do with your job

• Personal or comfort items given for the ease of use for members, families, doctors or other providers

• Procedures that are new or still being tested

• Drugs that are not approved by the U.S. Food and Drug Administration

• Elective abortion

• Sterilization reversals

• Fertility treatments such as artificial insemination or in-vitro fertilization

• Weight loss drugs or diet aids

• Cosmetic drugs

• Drugs that help grow hair

• Syringes or needles that are not ordered by your doctor

• Acupuncture

• Cosmetic surgery done to change or reshape normal body parts so they look better.
  – This does not apply to reconstructive surgery to give you back the use of a body part or to correct a deformity caused by an injury.

• Medical or surgical transsexual treatment services

• Foot care like nail trimming (this is covered if a member has diabetes)

• Medical services in an emergency room setting for health issues that are not emergencies

• Any service not covered under the Fee-for-Service program that is not listed as covered

Note: This is not a full list of services not covered by the Plan. You can always call Member Services if you have any questions about what is and is not covered.
Get the Most from Your Plan: Details and Benefits

ADDED BENEFITS

NO COPAYS

- $0 for doctor visits
- $0 for emergency room (ER) visits
- $0 for prescriptions

PRESCRIPTIONS

Members can get Over-the-Counter (OTC) medications and medical supplies. A full listing is in the Drug List (Formulary) that is in the Welcome Kit. You may order OTC medications and medical supplies once each quarter (three calendar months) for up to $30 per order.

DENTAL

- Dental is covered as a standard benefit for all of our members. See details on page 14. Members over age 21 can get two (2) cleanings per year as an Added Benefit.
- Dental Practice Visits - Members with developmental disabilities or serious mental illness can go for practice visits to the dentist.

OPTICAL (VISION)

As part of the standard benefit, members can get one pair of eyeglasses every two years. As an added benefit, members can get up to $40 towards a pair of upgraded eyeglass frames.

TRANSPORTATION

In addition to the standard benefit of transportation to covered services, members can also get a ride to the pharmacy after a provider appointment, or to a medical equipment provider, or to the local Women, Infants, and Children (WIC) food assistance office.

WELLNESS

- Healthy Incentives Programs - Members may be able to get gift cards for completing preventive services or going to the doctor after certain hospital or ER visits.
- Disease Management - Members who take part in this program may be able to get free OTC items.
- Weight Management – Members get nutrition guidance and health education with this program.
- Care Coordination – Member may work with a Care Coordinator for many health related needs.

MATERNITY CARE

- Special Beginnings Program – Pregnant members who join Special Beginnings get a personal nurse to guide them through pregnancy and delivery. The program also has classes and other support.
- Prenatal and postpartum rewards – Members who join Special Beginnings and go to their checkup appointments can get:
  - Infant car seat or portable crib
  - Diapers

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HOW TO FILL YOUR PRESCRIPTIONS

HOW DO I GET MY MEDICINES?

Make sure to take your Member ID card, your HFS medical card, and your prescription or medicine order from your doctor when you visit the pharmacy.

The Plan uses a Preferred Drug List (PDL) to help your doctor choose which drugs to give you. Certain drugs on this list need an OK from us ahead of time or have limits based on medical necessity. Even though a drug is on the PDL, your doctor will choose which drug is best for you.

To find out if a drug is on the PDL, please call Member Services or visit our website. A copy of the drug list is also included in your member packet.

You will need to get your medication at a network pharmacy, and you will receive up to a 30-day supply. There is no cost to you. Call Member Services if you have questions or need help.

To protect your health and keep you safe, make sure your doctor or pharmacist knows what medicines you are taking, including over-the-counter drugs.

OVER-THE-COUNTER (OTC) DRUGS

Over-the-counter (OTC) drugs are medicines you can buy at the pharmacy without a prescription. The Plan covers, at no cost to you, certain OTC drugs that are included on the PDL. You will need a valid medication order from your doctor to use this benefit. These products are to be filled at a Plan network pharmacy and for quantities up to a 30-day supply.

NETWORK PHARMACIES

There are many pharmacies in the network. To find one in your area, visit our website or call Member Services.

DRUGS NOT ON THE PDL

Call Member Services to find out if your drug is on the PDL. If it is not, you have two options:

• Talk to your doctor to decide if you can first try a drug that is on the PDL before you ask for an exception.

• Call Member Services to ask for an exception to cover your drug. Send a statement from your doctor backing your request. We must decide within 10 days of getting your doctor’s statement.

We usually only approve requests for exceptions if other drugs on the PDL or added-use limits would make your treatment less effective and/or would be harmful to your health.

You or your doctor can ask for a rush decision if you both believe that your health could be harmed by waiting up to 10 days for a decision. If we agree to rush, we must give you a decision within 24 hours (one day) after we get the statement from your doctor.

IF YOU NEED HELP GETTING TO THE PHARMACY

Call Member Services if you need help getting to your pharmacy. There is also information on Non-emergency Transportation on page 19.
**HOW TO RESOLVE A PROBLEM WITH BLUE CROSS COMMUNITY FAMILY HEALTH PLAN**

Call Member Services if you have a complaint. Your satisfaction is important to us.

**GRIEVANCES AND APPEALS**

We want you to be happy with services you get from Blue Cross Community Family Health Plan and our providers. If you are not happy, you can file a grievance or appeal.

**GRIEVANCES**

A grievance is a complaint about any matter other than a denied, reduced or terminated service or item.

Blue Cross Community Family Health Plan takes member grievances very seriously. We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, you should let us know right away. Blue Cross Community Family Health Plan has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits coverage.

**These are examples of when you might want to file a grievance:**

- Your provider or a Blue Cross Community Family Health Plan staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a Blue Cross Community Family Health Plan staff member was rude to you.
- Your provider or Blue Cross Community Family Health Plan staff member was insensitive to your cultural needs or other special needs you may have.

You can file your grievance on the phone by calling Member Services. You can also file your grievance in writing via mail or fax at:

- **Blue Cross Community Family Health Plan**
- **Attn: Grievance and Appeals Unit**
- **P.O. Box 27838**
- **Albuquerque, NM 87125-9705**
- **Fax: 1-866-643-7069**

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, names of the people involved and details about what happened. Be sure to include your name and your member ID number.

You can ask us to help you file your grievance by calling Member Services.

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file your grievance. If you are hearing-impaired, call the Illinois Relay at 711.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be “your representative.” If you decide to have someone represent you or act for you, inform Blue Cross Community Family Health Plan in writing with the name of your representative and his or her contact information.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information.
APPEALS
You may not agree with a decision or an action made by Blue Cross Community Family Health Plan about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within **60 calendar days** of the date on our Notice of Action form. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than **10 calendar days** from the date on our Notice of Action form.

The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not advising you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a “Notice of Action” letter from us. This letter will tell you the following:

- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it and when you may have to pay for the services

Here are two ways to file an appeal.

- Call Member Services at **1-877-860-2837** (TTY/TDD **711**). If you file an appeal over the phone, you must follow it with a written signed appeal request.
- Mail or fax your written appeal request to:
  
  Blue Cross Community Family Health Plan
  Attn: Grievance and Appeals Unit
  P.O. Box 27838
  Albuquerque, NM 87125-9705
  Fax: 1-866-643-7069

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file your appeal. If you are hearing impaired, call the Illinois Relay at **711**.

Can someone help you with the appeal process?
You have several options for assistance. You may:

- Ask someone you know to assist in representing you. This could be your PCP or a family member, for example.
- Choose to be represented by a legal professional.
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also call CAP (Client Assistance Program) to request their assistance at:
  
  **1-800- 641-3929** (Voice) or **1-888-460-5111** (TTY).

To appoint someone to represent you, either 1) send a letter informing us that you want someone else to represent you and include in the letter his or her contact information or, 2) fill out the Authorized Representative Appeals form. You may find this form on our website at [www.bcbsilcommunityfamilyhealthplan.com](http://www.bcbsilcommunityfamilyhealthplan.com).
APPEAL PROCESS

We will send you an acknowledgement letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing. A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce or stop the medical service.

Blue Cross Community Family Health Plan will send our decision in writing to you within 15 business days of the date we received your appeal request. Blue Cross Community Family Health Plan may request an extension up to 14 more calendar days to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension, if you need more time to obtain additional documents to support your appeal.

We will call to tell you our decision and send you and your authorized representative the Decision notice. The Decision notice will tell you what we will do and why.

If Blue Cross Community Family Health Plan’s decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review.

If Blue Cross Community Family Health Plan’s decision does not agree with the Notice of Action, we will approve the services to start right away.

Things to keep in mind during the appeal process:

- At any time, you can provide us with more information about your appeal, if needed.
- You have the option to see your appeal file.
- You have the option to be there when Blue Cross Community Family Health Plan reviews your appeal.

How can you expedite your appeal?

If you or your provider believes our standard timeframe of 15 business days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Action letter, information about your case, and why you are asking for the expedited appeal.

We will let you know within 24 hours if we need more information. Once all information is provided, we will call you within 24 hours to inform you of our decision and will also send the Decision Notice to you and your authorized representative.

How can you withdraw an appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process.

However, you or your authorized representative must do so in writing, using the same address used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request.

To withdraw an appeal, you can either, 1) send us a letter advising us that you would like to withdraw your appeal, or 2) fill out the Withdrawal Form. You may find this form on our website at [www.bcbsilcommunityfamilyhealthplan.com](http://www.bcbsilcommunityfamilyhealthplan.com) or call us at 1-877-860-2837 or TTY/TDD 711.

Blue Cross Community Family Health Plan will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call Blue Cross Community Family Health Plan Member Services at 1-877-860-2837 (TTY/TDD 711).

What happens next?

After you receive the Blue Cross Community Family Health Plan appeal Decision Notice in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing Appeal and/or asking for an External Review of your appeal within 30 calendar days of the date on the Decision Notice. You can choose to ask for both a State Fair Hearing Appeal and an External Review or you may choose to ask for only one of them.
STATE FAIR HEARING

If you choose, you may ask for a State Fair Hearing Appeal within **thirty (30) calendar days** of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within **ten (10) calendar days** of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for the services provided to you during the appeal process.

At the State Fair Hearing, just like during the Blue Cross Community Family Health Plan Appeals process, you may ask someone to represent you, such as a lawyer or have a relative or friend speak for you. To appoint someone to represent you, send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information.

You can ask for a State Fair Hearing in one of the following ways:

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver Community Care Program (CCP) services, send your request in writing to:

  *Illinois Department of Healthcare and Family Services*
  *Bureau of Administrative Hearings*
  *69 W. Washington Street, 4th Floor*
  *Chicago, IL 60602*
  *Fax: (312) 793-8573*
  *Email: DHS.HSPAppeals@illinois.gov*
  *Or you may call 1-800-435-0774 (TTY: 1-877-734-7429)*

*STATE FAIR HEARING PROCESS*

The hearing will be conducted by an Impartial Hearing Officer authorized to conduct State Fair Hearings. You will receive a letter from the appropriate Hearings Office informing you of the date, time and place of the hearing. This letter will also provide information about the hearing. It is important that you read this letter carefully.

At least three (3) business days before the hearing, you will receive information from Blue Cross Community Family Health Plan. This will include all evidence we will present at the hearing. This will also be sent to the Impartial Hearing Officer. You must provide all the evidence you will present at the hearing to Blue Cross Community Family Health Plan and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

You will need to notify the appropriate Hearings Office of any accommodation you may need. Your hearing may be conducted over the phone. Please be sure to provide the best phone number to reach you during business hours in your request for a State Fair Hearing. The hearing may be recorded.

Additional Resources

Member Services: 1-877-860-2837 • TTY/TDD 711 • 24/7 Nurseline: 1-888-343-2697
CONTINUANCE OR POSTPONEMENT
You may request a continuance during the hearing, or a postponement prior to the hearing, which may be granted if good cause exists. If the Impartial Hearing Officer agrees, you and all parties to the appeal will be notified in writing of a new date, time and place.

The time limit for the appeal process to be completed will be extended by the length of the continuation or postponement.

FAILURE TO APPEAR AT THE HEARING
Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time.

A Dismissal Notice will be sent to all parties to the appeal.

Your hearing may be rescheduled, if you let us know within 10 calendar days from the date you received the Dismissal Notice, if the reason for your failure to appear was:

• A death in the family
• Personal injury or illness which reasonably would prohibit your appearance
• A sudden and unexpected emergency

If the appeal hearing is rescheduled, the Hearings Office will send you or your authorized representative a letter rescheduling the hearing with copies to all parties to the appeal.

If we deny your request to reset your hearing, you will receive a letter in the mail informing you of our denial.

THE STATE FAIR HEARING DECISION
A Final Administrative Decision will be sent to you and all interested parties in writing by the appropriate Hearings Office. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as 35 days from the date of this letter. If you have questions, please call the Hearing Office.

EXTERNAL REVIEW (FOR MEDICAL SERVICES ONLY)
Within 30 calendar days after the date on the Blue Cross Community Family Health Plan appeal Decision Notice, you may choose to ask for a review by someone outside of Blue Cross Community Family Health Plan. This is called an external review. The outside reviewer must meet the following requirements:

• Board certified provider with the same or like specialty as your treating provider
• Currently practicing
• Have no financial interest in the decision
• Not know you and will not know your identity during the review

Your letter must ask for an external review of that action and should be sent to:

Blue Cross Community Family Health Plan
Attn: Grievance and Appeals Unit
P.O. Box 27838
Albuquerque, NM 87125-9705
Fax: 1-866-643-7069
What happens next?

- We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.

- You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer.

The external reviewer will send you and/or your representative and Blue Cross Community Family Health Plan a letter with their decision within five (5) calendar days of receiving all the information they need to complete their review.

EXPEDITED EXTERNAL REVIEW

If the normal time frame for an external review could jeopardize your life or your health, you or your representative can ask for an expedited external review. You can do this over the phone or in writing.

To ask for an expedited external review over the phone, call Member Services toll-free at 1-877-860-2837 (TTY/TDD 711). To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Your letter must ask for an expedited external review of that action and should be sent to:

Blue Cross Community Family Health Plan
Attn: Grievance and Appeals Unit
P.O. Box 27838
Albuquerque, NM 87125-9705
Fax: 1-866-643-7069

What happens next?

- Once we receive the phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative to give you the name of the reviewer.

- We will also send the necessary information to the external reviewer so they can begin their review.

- As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and Blue Cross Community Family Health Plan know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Blue Cross Community Family Health Plan with the decision within 48 hours.

OTHER THINGS YOU MAY NEED TO KNOW

You may have questions that have not have been answered in this book. Look through this section for the answers.

CONTACTING MEMBER SERVICES

Call Member Services:
1-877-860-2837 (TTY/TDD 711)

Hours of Operation:

- We are open between 8 a.m. to 8 p.m., Central time, seven (7) days a week from October 1 to February 14.

- From February 15 to September 30, we are open 8 a.m. to 8 p.m., Central time, Monday through Friday.

- Alternative technologies (for example, voicemail) will be used on the weekends and federal holidays. The call is free.
Additional Resources

Our staff is trained to help you understand your health plan. We can give you details about:

- Eligibility
- Benefits
- Getting services
- Interpreter services, language services including sign language
- Choosing or changing your PCP
- Your health plan
- Vision and dental services
- How to get prescription drugs
- Transportation
- Complaints and appeals
- Rights and Responsibilities

How do I get medical care after my Primary Care Provider’s office is closed?

If you call your doctor after business hours, you will:

- Find out how to reach an on-call doctor
- Get connected to an on-call doctor
- Get a call back within 30 minutes

ABUSE, NEGLECT, FRAUD

Abuse can happen to anyone, anywhere—in a person’s own home, in nursing homes or assisted living facilities, even in hospitals.

Warning Signs

Abuse can take many different forms:

- **Physical abuse** is any inappropriate contact that causes bodily harm. Examples of physical abuse include being slapped, scratched, pushed or threatened with a weapon such as a knife or gun. Warning signs may include unexplained fractures, bruises, welts, cuts, sores, or burns.
- **Sexual abuse** is any sexual behavior or intimate physical contact that occurs without a person’s permission. This can include touching a person’s genital area, buttocks or breasts.
- **Mental abuse** is emotional distress caused by the use of demeaning or threatening words. Mental abuse can also include signs, gestures and other actions. For example, controlling behavior, embarrassment or social isolation are types of mental abuse.
- **Financial abuse** is the use of a person’s money without their consent. Examples of financial abuse can include improper use of guardianship or power of attorney, using your credit card or cashing your checks without your consent.

What is Neglect?

Neglect is another form of abuse that takes place when someone fails to provide, or withholds, the necessities of life, such as food, clothing, shelter, or medical care. The warning signs of neglect can include a lack of basic hygiene or not providing proper food or fluids.

What is Fraud?

Fraud takes place when a person receives benefits or payments to which they are not entitled. Please let us know if you are aware of someone who is committing fraud under the Medicaid program. This could be a provider or a member.

Some examples of fraud include:

- A lie on an application
- Using another person’s ID card
- A provider (doctor) billing for services that were not done
- Transportation (usage abuse)
If You Suspect Abuse, Report It

By law, it is your responsibility to report allegations of abuse and neglect to the Illinois Department of Human Services (DHS), Illinois Department of Public Health (DPH), or Illinois Department on Aging (DOA).

- If the person is enrolled in a program or lives in a setting funded, licensed or certified by DHS or lives in a private home, call the OIG Hotline: 1-800-368-1463
- If the person with disabilities is enrolled in a program or lives in a setting funded, licensed or certified by DPH (e.g. nursing home) and the abuse/ neglect occurs when services are being provided, call the DPH Nursing Home Hotline: 1-800-252-4343 TTY 1-800-547-0466.
- If the abuse/ neglect is an adult age 60 or older who does not live in a nursing home, call DOA’s Senior Helpline: 1-800-252-8966.

You can also report any suspected areas of fraud or abuse to us by calling Blue Cross Community Family Health Plan Member Services at 1-877-860-2837 (TTY/TDD 711).

You can also use our Fraud and Abuse hotline at 1-800-543-0867.

All information will be kept private.
Eliminating abuse, neglect and fraud is the responsibility of everyone.

ADVANCE DIRECTIVES (LIVING WILLS)

What are Advance Directives?
Advance directives are legal documents that state how you want to be treated if you cannot talk or make decisions.

What if I am too sick to make a decision about my medical care?
You can name a person who will make decisions for you if you are too sick to do so. This is called a health care power of attorney. You must give this person permission in writing to make your health care decisions for you.

You may want to list the types of care you do or do not want. For instance, some people do not want to be put on life-support machines if they go into a coma.

Your PCP will note your Living Will in your medical records. That way, your doctor caring for you will know what you want.

You have the right to set up papers with these details for your doctor and other health care providers to use.

These are called Advance Directives for Health Care. Ask your family, PCP, Care Coordinator, or someone you trust to help you. You may change or take back your Living Will at any time.

How do I get an Advance Directive?
Illinois law allows for the following three types of advance directives:
- Health care power of attorney
- Living will
- Mental health treatment preference declaration

In addition, you can ask your physician to work with you to prepare a Do Not Resuscitate (DNR) order.

You may choose to discuss with your health-care professional and/or attorney these different types of advance directives as well as a DNR order.

For more information, visit the State of Illinois Department of Health at www.idph.state.il.us/public/books/advin.htm or call the department’s customer service line at 1-217-782-4977.

YOUR MEDICAL RECORDS

Federal and state laws allow you to see your medical records. Ask for your records from your PCP first.
If you have a problem getting your medical records from your PCP, call Member Services.
Member Rights and Responsibilities

PRIVACY POLICIES
We have the right to get information from anyone giving you care. We use this information so we can pay for and manage your health care. We keep this information private between you, your health care provider, and us, except as the law allows. Refer to the Notice of Privacy Practices to read about your right to privacy. This notice was included in your new member packet. If you would like a copy of the notice, please call Member Services.

Information available to members
As a member, you can ask for and get the following information each year:

- Information about network providers — at a minimum, primary care doctors, specialists and hospitals in our service area. This information will include names, addresses, telephone numbers and languages spoken (other than English) for primary care providers, plus identification of providers that are not accepting new patients
- Provider information is updated on our website at minimum two times each month. You can call the Member Services if you do not have access to the Internet
- Any limits on your freedom of choice among network providers
- Your rights and responsibilities
- Information on complaint, appeal and fair hearing procedures
- Information about benefits available under the Medicaid program, including amount, duration and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled
- How you get benefits including authorization requirements
- How you get benefits, including family planning services, from out-of-network providers and/or the limits to those benefits
- How you get after hours and emergency coverage and/or the limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services and post-stabilization services
  - The fact that you do not need prior authorization from your primary care provider for emergency care services
  - How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid
  - A statement saying you have a right to use any hospital or other settings for emergency care
  - Post-stabilization rules
- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider
- The Plan practice guidelines

AMERICANS WITH DISABILITIES ACT
We follow the rules of the Americans with Disabilities Act (ADA) of 1990. This act protects you from being treated in a different way by us because of a disability. If you feel you have been treated in a different way because of a disability, call Member Services.
YOUR HEALTH CARE RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS AND RESPONSIBILITIES

Every member has the following rights and responsibilities:

1. You have the right to respect, dignity, and privacy. That includes the right to:
   a. Nondiscrimination
   b. Know that your medical records and discussions with your providers will be kept private and confidential
   c. Request and receive your medical records and if needed, have them corrected

2. You have the right to a fair opportunity to choose a health care plan and primary care provider, the doctor or health care provider you will see most of the time. You also have the right to change your plan or your provider without penalty at any time. That includes the right to:
   a. Be told how to choose a health plan and primary care provider available in your area
   b. Be told how to change your health plan or your primary care provider

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated
   b. Be told why care or services were denied and not given

4. You have the right to agree to or refuse treatment and have a say in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you
   b. Say “yes” or “no” to the care recommended by your provider

5. You have the right to use each complaint and appeal process available through the Managed Care Organization and through Medicaid. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan
   b. Get a timely answer to your complaint
   c. Use the Plan’s appeal process and be informed on how to submit a complaint
   d. Ask for a fair hearing from the state Medicaid program and get information about how that process works
MEMBER RIGHTS AND RESPONSIBILITIES (CONTINUED)

6. You have the right to quick and easy access to care. That includes the right to:
   a. Have telephone access to a medical professional twenty-four (24) hours a day, seven (7) days a week for any emergency or urgent care you need
   b. Receive medical care in a timely manner
   c. Get in and out of a health care provider’s office easily. There shouldn’t be any conditions that limit movement for people with disabilities according to the Americans with Disabilities Act
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters are people who can speak in your native language, help someone with a disability, or help you understand the information
   e. Be given information you can understand about your health plan rules, the health care services you can get and how to get them

7. You have the right to refuse to be restrained or secluded for someone else’s convenience or as a way of forcing you to do something you don’t want to do, or as punishment.

8. You have a right to know that your health plan can’t prevent doctors, hospitals and others who care for you from advising you about your health status, medical care and treatment, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals and others can’t require you to pay copayments or any other amounts for covered services.

10. If you are an American Indian member, you have the right to receive services from an Indian Health Care Provider, whether the provider is in or out of network.
YOUR RESPONSIBILITIES:

1. Read and follow the member handbook.

2. Keep your scheduled appointments or call your provider to reschedule or cancel at least 24 hours before your appointment.

3. Show your ID card to each provider before getting medical services.

4. Call your PCP or 24/7 Nurseline before going to an emergency room, except in situations that you believe are life threatening or that could permanently damage your health.

5. You can see a Blue Cross and Blue Shield of Illinois specialist without a referral from your PCP, but it is important that your PCP knows which doctors you see.

6. Call Member Services if you change your phone number or your address. You also should contact your Case Worker at Department of Human Services (DHS).

   Share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:

   a. Tell your primary care provider about your health
   b. Talk to your providers about your health care needs and ask questions about the different ways your health problems can be treated
   c. Help your providers get your medical records
   d. Treat your providers and other health care employees with respect and courtesy

7. Be involved in service and treatment option decisions. Make personal choices to keep yourself healthy. That includes the responsibility to:

   a. Work as a team with your provider in deciding what health care is best for you
   b. Understand how the things you do can affect your health
   c. Do the best you can to stay healthy
   d. Treat providers and staff with respect
   e. Talk to your provider about all of your medications

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You can also view information concerning the HHS Office for Civil Rights online at www.hhs.gov/ocr.
24/7 Nurseline – 24-hour a day help line ....................................................... 1-888-343-2697, TTY/TDD 711
Emergency Care ............................................................................................................................ 911

Blue Cross Community Family Health Plan Member Services .......................... 1-877-860-2837, TTY/TDD 711

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October 1 to February 14
8 a.m. to 8 p.m., Central time
Seven (7) 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 federal holidays.
The call is free.

Blue Cross Community Family Health Plan Special Investigation Department (SID) ....................... 1-800-543-0867
National Poison Control Center ...................................................................................... 1-800-222-1222
Calls are routed to the office closest to you.

Non-Emergency Medical Transportation ............................................................................ 1-877-860-2837, TTY/TDD 711
Dental (DentaQuest) ............................................................................. 1-855-225-1733, TTY/TDD 711
Vision (Davis Vision) ............................................................................. 1-866-847-4661, TTY/TDD 711
Transportation (MTM) ............................................................................... 1-844-549-8348, TTY/TDD 711
Behavioral Health Services ............................................................................. 1-877-860-2837, TTY/TDD 711
Pharmacy Services ............................................................................... 1-877-860-2837, TTY/TDD 711
Grievances and Appeals ............................................................................... 1-877-860-2837, TTY/TDD 711
Fraud and Abuse ............................................................................... 1-800-543-0867, TTY/TDD 711
Critical Incident Hotline ............................................................................... 1-855-653-8127, TTY/TDD 711
Adult Protective Services .......................................................... 1-866-800-1409, TTY 1-888-206-1327
Nursing Home Hotline ............................................................................. 1-800-252-4343, TTY 1-800-547-0466
Department of Rehabilitation Services (DORS) ....................................................... 1-800-843-6154, TTY 1-800-447-6404

Web .............................................................................................................. www.bcbsilcommunityfamilyhealthplan.com

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