

---

## Member Handbook

**Effective Date: 01/01/2018**

**Member Services: 1-877-860-2837**

**(TTY/TDD: 711)**

**[www.bcchpil.com](http://www.bcchpil.com)**



# Getting Started

## How to Use This Handbook

You will find this handbook easy to use. Here are some tips to help you to get started and save time:

### Read these parts first:

- How to use your Blue Cross Community Health Plans
- Important Things to Do
- Emergency and Urgent Care Services

### Then read:

- Covered Services
- Non-Covered Services
- Disease/Health Education Management Programs

### Also read:

- Important Phone Numbers
- Appeals Process
- Rights and Responsibilities

If you need help with this handbook, call Member Services at **1-877-860-2837** (TTY/TDD: **711**).

## Important Things to Do

**Always keep your Blue Cross Community Health Plans identification card (ID) with you. Also, keep your Illinois Department of Healthcare and Family Services (HFS) medical card.** Show it every time you need health care services. Don't 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. You should use an in-network provider for all non-emergency services.

**Set up an initial health exam with your PCP right away.** Adults should have their first health exam within 30 days of joining the Plan. During the first exam, the PCP will learn about your health care needs. This is to help you stay healthy. Call Member Services if you need a ride to and from non-emergency medical visits.

**If it's 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 don't need an approval from the Plan or your PCP for emergency care. It doesn't matter if you are inside or outside the network service area. You will be covered for emergency services in the U.S.

**If you have a health problem, you can talk to a nurse at 24/7 Nurseline.** They can be reached at **1-888-343-2697**. Have your ID card ready when you call.

# Getting Care – How to Use Your Blue Cross Community Health Plans

## Your Plan Membership

### Service Area

The Plan covers members who live in the state of Illinois.

### Care while traveling

Call Member Services using the number on your ID card. 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 in all of the U.S.

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.

### Care outside the United States

The Plan does not cover services outside the United States

## Help in Other Languages

### Can someone interpret for me when I speak with my doctor?

The Plan offers interpreter services for many languages, and includes:

- Health education materials in English and Spanish
- Member Services staff that speaks English and Spanish
- Phone interpreter services
- Sign language and face-to-face interpreter services
- Providers who speak two languages

### How can I get a face-to-face interpreter in the provider's office?

You can ask for a face-to-face or phone interpreter at no charge. Please call Member Services. 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?

Call us at least 72 hours (three business days) in advance. We'll be glad to help. You don't have to use a family member or a friend to translate for you unless that is your choice.

# Welcome to Blue Cross Community Health Plans

## Intro to Plan:

The Blue Cross Community Health Plans were created with wellbeing in mind. That's why you have access to benefits and resources. We cover a wide range of services and benefits. This handbook will help you understand your coverage. It will help you get the healthcare services you need.

Blue Cross Community Health Plans is also known as a Managed Care Organization (MCO). We cover services for those who qualify for the Illinois Medical Assistance program. Joining is easy.

## Eligibility:

You can join if **ONE** of the following describes you:

- You are a family or child and you qualify for Medicaid through Title XIX or Title XXI (Children's Health Insurance Program).
- You are an adult who qualifies for Medicaid as defined by the Affordable Care Act (ACA). This means your monthly income is less than 138% of federal poverty level.
- You are under age 21 and eligible for Medicaid through one of the following:
  - Supplemental Security Income (SSI)
    - You receive Supplemental Security Income (SSI) and are 19 or older
    - A disability and are 19 or older
- You qualify for Medicaid but not Medicare and are either:
  - Age 65 or older but do not have Medicare

# Important Phone Numbers

24/7 Nurseline – 24-hour-a-day help line	<b>1-888-343-2697, TTY/TDD: 711</b>
Emergency Care	<b>911</b>
<b>Blue Cross Community Health Plans Member Services</b> We are available 24 hours a day, seven (7) days a week. The call is free. <b>Website:</b> <a href="http://www.bcchpil.com">www.bcchpil.com</a> <b>Service Area:</b> The plan covers members who live in the state of Illinois.	<b>1-877-860-2837, TTY/TDD: 711</b>
Blue Cross Community Health Plans Special Investigation Department (SID)	<b>1-800-543-0867</b>
National Poison Control Center <b>Calls are routed to the office closest to you.</b>	<b>1-800-222-1222</b>
Non-Emergency Medical Transportation	<b>1-877-831-3148,</b> TTY/TDD: <b>1-866-288-3133</b>
Behavioral Health Services	<b>1-877-860-2837, TTY/TDD: 711</b>
Mobile Crisis Response	<b>1-800-345-9049, TTY/TDD: 711</b>
Grievances and Appeals	<b>1-877-860-2837, TTY/TDD: 711</b>
Fraud and Abuse	<b>1-800-543-0867, TTY/TDD: 711</b>
Care Coordination	<b>1-855-334-4780, TTY/TDD: 711</b>
Adult Protective Services	<b>1-866-800-1409 TTY: 1-888-206-1327</b>
Nursing Home Hotline	<b>1-800-252-4343, TTY: 1-800-547-0466</b>
DentaQuest	<b>1-888-291-3763</b>
Davis Vision	<b>1-888-715-6716</b>
Illinois Department of Health	<b>1-217-782-4977</b>

# Member Handbook

## Table of Contents

Member Services .....	1
Member Identification (ID) Card .....	1
Open Enrollment .....	2
Provider Network .....	2
Primary Care Provider (PCP) .....	3
How to Change PCPs.....	3
Women's Health Care Provider (WHCP) .....	4
Family Planning .....	5
Specialty Care.....	5
Prior Authorization (Getting an OK from the Plan) .....	6
Scheduling Appointments.....	7
Urgent Care .....	7
Emergency Care.....	8
Post-Stabilization Care.....	8
Covered Services .....	9

<b>Covered Medical Services .....</b>	<b>9</b>
Annual Adult Well Exams .....	9
Audiology Services .....	9
Behavioral Health Services.....	9
Chiropractor Services .....	10
Colorectal Cancer Screening .....	10
Diagnostic and Therapeutic Radiology .....	10
Doctor Services .....	10
Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services.....	10
Emergency and Urgent Care Services .....	10
Family Planning Services .....	11
Home Health Care Services.....	11
Hospice Services (including Palliative).....	11
Hospital Services .....	12
Laboratory and X-ray Services .....	13
Medical Equipment and Supplies.....	13
Nursing Care Services.....	13
Nursing Facilities Services .....	13
Physical Therapy, Occupational Therapy and Speech Pathology .....	13
Substance Abuse .....	14
<b>Covered Home and Community Based Services (Waiver clients only) .....</b>	<b>15</b>
<b>Managed Long Term Support &amp; Services (MLTSS) Covered Services.....</b>	<b>16</b>
<b>Limited Covered Services .....</b>	<b>16</b>
<b>Non-Covered Services.....</b>	<b>17</b>
<b>Dental Services .....</b>	<b>18</b>
<b>Vision Services.....</b>	<b>18</b>
<b>Pharmacy Services.....</b>	<b>19</b>
<b>Transportation Services .....</b>	<b>20</b>
<b>Added Benefits .....</b>	<b>21</b>
<b>Care Coordination .....</b>	<b>22</b>



<b>Disease/Health Education Management Programs.....</b>	<b>22</b>
<b>The Ombudsman Program .....</b>	<b>24</b>
<b>Recipient Restriction Program .....</b>	<b>25</b>
<b>Advance Directives .....</b>	<b>25</b>
<b>Grievance &amp; Appeals .....</b>	<b>26</b>
<b>Rights &amp; Responsibilities.....</b>	<b>33</b>
<b>Fraud, Abuse and Neglect .....</b>	<b>34</b>
<b>Privacy Policy .....</b>	<b>34</b>
<b>Definitions.....</b>	<b>35</b>
<b>Disclaimers.....</b>	<b>37</b>



# Member Services

Welcome to Blue Cross Community Health Plans

Our Member Service Department is ready to help you get the most from your health plan.

- Member Services available at **1-877-860-2837** (TTY/TDD **711**). We are available 24 hours a day, seven (7) days a week.
- **Our staff is trained to help you understand your health plan. We can give you details about:**
  - Your Health Plan
  - Help in Other Languages
  - Open Enrollment
  - Covered/Non-Covered Services
  - Choosing/Changing your PCP
  - How to Get Prescription Drugs
  - Vision and Dental Services
  - Transportation
  - Grievance & Appeals
  - Rights and Responsibilities

## Telephone Access

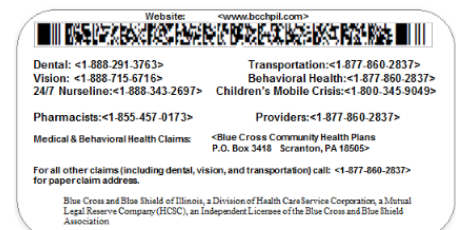
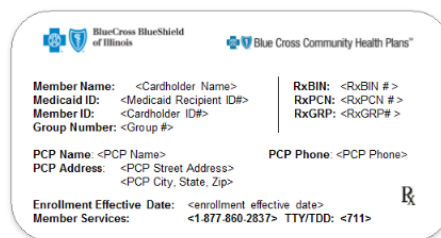
- You can reach your PCP 24 hours a day at the PCP number on your ID card. After regular business hours, leave your name and phone number with the answering service. Either your PCP or an on-call doctor will call you back. If you have an emergency, call 911 or go to the nearest ER. You can also call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

# Member Identification (ID) Card

You will receive a Member ID Card. You should always carry your card with you. It has important phone numbers. You will need to show it when you get services.

## Information on your Member ID Card:

- Name
- Plan Name
- State Medicaid ID #
- PCP information (name, address, phone number)
- Effective Date
- Member Services #
- 24/7 Nurseline
- Behavioral Health #
- Mobile Crisis Response #
- Dental #
- Transportation #
- Rx, Rxbin, Rxgroup, (information for providers when billing)
- Name & Address of MCO



- (where providers are to send claims)

**Providers are to send claims to:**

Blue Cross Community Health Plans  
c/o Member Services  
P.O. Box 3418  
Scranton, PA 18505

**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

## Open Enrollment

Once each year, you can change health plans during a specific time called "Open Enrollment". Client Enrollment Services (CES) will send you an open enrollment letter approximately 60 days prior to your anniversary date. Your anniversary date is one year from your health plan start date. You will have 60 days during your open enrollment to make a one plan switch by calling CES at **1-877-912-8880**. After the 60 days has ended, whether a plan switch was made or not, you will be locked in for 12 months. If you have questions regarding your enrollment or disenrollment with Blue Cross Community Health Plans please contact the Client Enrollment Service (CES) at **1-877-912-8880**.

## Provider Network

The Blue Cross Community Health Plans network is made up of doctors, specialists and hospitals. These providers are contracted with Blue Cross and Blue Shield of Illinois (BCBSIL) to provide medical services to you.

You should use in-network providers. If you choose to see a doctor who is not part of our network, you will have to pay for the services. Except in an emergency, the plan does not cover out-of-network services. Ask the provider if they are in the network before you get care.

You may need to get approval for some services before you are treated. This is called "prior-authorization." Blue Cross Community Health Plans may not cover the service if you don't get approval.

If you need help finding a doctor, call Blue Cross Community Health Plans at **1-877-860-2837 (TTY/TDD 711)**.

### Other Providers

- **Dental coverage** is available through DentaQuest®: <http://www.dentaquest.com/dentists/>
- **Vision coverage** is available through Davis Vision®: <https://www.davisvision.com/Providers/>

# Primary Care Provider (PCP)

Your primary care provider is your personal doctor who will give you most of your care. They may also send you to other providers if you need special care. With Blue Cross Community Health Plans, you can pick your PCP. You can have one PCP for your whole family or you can choose other PCPs for each family member.

You can always choose the following provider types to act as your PCP:

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

If you are an American Indian/Alaskan Native member, you have the right to get Tribe, Tribal Organization or Urban Indian Organization provider in and outside of the State of Illinois.

If you need help in finding or changing your PCP, please contact Member Services at **1-877-860-2837** (TTY/TDD **711**). We are available 24 hours a day, seven (7) days a week. The call is free.

## How to Change PCPs

You can change your PCP at any time by calling Member Services at **1-877-860-2837** (TTY/TDD **711**). We are available 24 hours a day, seven (7) days a week. The call is free. Unless a change is truly needed, it's best to keep the same PCP. This is so they 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's no limit on how many times you can change your PCP.

### What are the reasons a request to change a PCP may be denied?

- PCP is not taking new patients
- PCP is not in your network
- PCP is outside your service area

### When will my PCP change be made?

- If you ask to change your PCP anytime during the month, you may see your new PCP within 30 days of getting your request for change.
- You'll get a new ID card with your PCP's name and contact details on it.
- You are allowed to see your newly assigned PCP prior to receiving your new ID card.

### **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 your PCP. You should:

- Call us first to change your PCP, or
- Get an OK from us before you use the non-PCP doctor

### **Provider Directory**

You may view the Provider Directory online or in print. Look under Family Practice, Internal Medicine or Geriatrics to choose a PCP. Call Member Services if you need a copy of the directory or need help.

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

- Does the PCP have handicap accessible facilities?
- What language does the PCP speak?
- Is the PCP's office open on weekends?

## **Women's Health Care Provider (WHCP)**

As a woman with Blue Cross Community Health Plans coverage, you have the right to select a Women's Health Care Provider (WHCP). A WHCP is a doctor licensed to practice medicine specializing in obstetrics, gynecology or family medicine.

### **Can I choose any WHCP as my PCP?**

You may select a WHCP as your PCP. However, the WHCP must be an in-network provider and accepting new patients.

### **Can I stay with my WHCP if they are not with the Plan?**

The WHCP must be included as part of the network.

### **Will I need prior authorization?**

No prior authorization is needed to see a WHCP in-network.

### **How do I choose a WHCP or PCP?**

Look in the Plan Provider Directory for PCPs and WHCPs who work with the 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.

# Family Planning

Blue Cross Community Health Plans has a network of Family Planning providers where you can get family planning services; however, you may choose to get family planning services and supplies from any out of network provider without a referral and it will be covered.

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

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.

# Specialty Care

A Specialist is a doctor who cares for you for a certain health condition. An example of a Specialist is Cardiology (heart health), Orthopedics (bones and joints). If your PCP thinks you need a specialist, they will work with you to choose a specialist. Your PCP will arrange your specialty care. As a member you can see an in-network specialist without a referral.

## Seeing a doctor who is a 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.

- Tell your PCP as much as you can about your health so both of you can decide what's best.
- A specialist may treat you for as long as they think you need it.
- You should tell your PCP you are seeing a specialist so they can coordinate your care.
- Specialist must be in the network for the Plan to pay for covered services.

## Wait time for an appointment

The amount of time depends on the type of care you need. Blue Cross Community Health Plans will help you find the care you need as soon as possible. Out-of-network services aren't covered unless you get an OK from us before you get the service.

## Getting help for special needs

Call Member Services for help getting the care you need. The Plan will allow you to see the specialists you need for identified conditions. This includes a standing (on-going) authorization to a specialist or having them as a PCP if needed.

# Prior Authorization (Getting an OK from the Plan)

Your PCP will get an OK from the Plan for some services. This is 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
- Finding out what’s wrong or treating the disease, illness or injury
- Help you do things like eating, dressing and bathing

Getting an OK takes no more than **3 calendar days**. If needed faster, it takes no more than **2 calendar days**. To check service limits, see the section called “Covered Medical Services”. Your PCP can also tell you about this.

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

We won’t pay for services from a provider that isn’t part of the Plan network if you didn’t get an OK from us before getting the services.

## What services do not need a referral (or an OK from my PCP)?

- Primary Care
- In-network Specialist
- Family Planning
- WHCP Services (you must choose doctors in the network)
- Emergency Care

## Deductibles and Copays

You don’t have to pay any deductibles or copays for approved services.

## What if I get a bill from my doctor?

In most cases, you shouldn’t get a bill from a Plan provider. You may have to pay for charges if:

- You agree to pay for services that aren’t covered or OK’d by the Plan
- You agree to pay for services from a provider who doesn’t work with the Plan and you didn’t get an OK ahead of time.

## 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. They 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 isn’t with the Plan.

Call Member Services for help getting a second opinion. You can also call the 24/7 Nurseline to learn more.



# Scheduling Appointments

It is very important that you keep all appointments you make for doctor visits, lab test, or X-rays. Tell the PCP you are a plan member. Have your ID card with you when you call. Please call your PCP at least one day ahead of time if you cannot keep an appointment. If you need help in making an appointment, please contact Members Services at **1-877-860-2837** (TTY/TDD **711**). We are available 24 hours a day, seven (7) days a week. The call is free.

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

If you are late, your PCP may not be able to see you.

## 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

## Routine Medical Care

*What is routine (regular) medical care? How soon can I expect to be seen?*

You get regular care, such as checkups, from your PCP. This is to help keep you healthy. You should be able to see your PCP within fourteen (14) days from the date you call to make your appointment.

**Note:** If you need family planning, you may go to any provider who takes Medicaid. See the section called Get the Most from Your Plan, to learn more about family planning.

# Urgent Care

Urgent care is an issue that needs care right away but is not life threatening.

Some examples of urgent care are:

- Minor Cuts and scrapes
- Colds
- Fever
- Ear ache

Call your Doctor for urgent care or you can call Blue Cross Community Health Plans Member Services at **1-877-860-2837** (TTY/TDD **711**). We are available 24 hours a day, seven (7) days a week. The call is free.

# Emergency Care

An emergency medical condition is very serious. It could even be life threatening. You could have severe pain, injury or illness.

Some examples of an emergency are:

- Chest pains
- Cannot breathe or choking
- Passing out or seizures
- Sick from poison or a drug overdose
- Broken bone
- Bleeding a lot
- Has been attacked
- About to deliver a baby
- Serious injury to the arm, leg, hand, foot or head
- Severe burn
- Severe allergic reaction
- Animal bite
- Trouble controlling behavior and, without treatment, is a danger to him/herself or others

## What to do in case of an emergency:

- Go to the nearest Emergency Department; you can use any hospital or other setting to get emergency services
- Call 911
- Call ambulance if no 911 service in area
- No referral is needed
- Prior authorization is not needed, but you should call us within 24 hours of your emergency care.

## How soon can I expect to be seen?

You will be seen as soon as possible. You should call your PCP after any emergency (home or away). Your PCP can plan your follow-up care. You must also call your care coordinator after an emergency. They need to know an emergency occurred. They can 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.

# Post-Stabilization Care

Post-Stabilization Services are needed services given to an Enrollee once the Enrollee is stabilized following an emergency medical condition, in order to make the Enrollee better.

Post stabilization services after an emergency are covered.

# Covered Services

## **We will pay for all covered services under Covered Medical Services.**

You may have to pay for care or services that are not listed, or are not medically necessary. If they are listed and are medically necessary, we will pay the full cost of the services.

Your PCP may send you to a specialist or other provider for medical tests. They may make the appointment for you. A referral is not required. Sometimes you will have to make the appointment yourself. This is called a self-referral. You may also call Member Services for help with appointments.

Blue Cross Blue Shield of Illinois shall provide and/or arrange for covered health care services to the Member in accordance with the provisions of the Certificate of Coverage. A description of covered health care services is also available in the Blue Cross Community Health Plans Certificate of Coverage.

Call Member Services if you have questions about what the Plan covers.

## Covered Medical Services

Here is a list of some of the medical services and benefits that Blue Cross Community Health Plans covers.

### **Annual Adult Well Exams**

Annual adult well exams are done by your PCP or WHCP. Physical exams are not part of family planning. A physical exam may include:

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

### **Audiology Services**

Hearing aids are covered for all members but require prior authorization. Hearing aids are limited to one (1) hearing aid/ ear every three (3) years. Batteries are limited to 32 per 60 days and require no prior authorization. Hearing screenings are only covered if you are under the age of 21. They are covered over the age of 21 if you have symptoms of an ear problem.

### **Behavioral Health Services**

If you have a behavioral health crisis, call **1-877-860-2837** TTY/TDD **711**. Someone will assist you, 24 hours a day seven days a week.

You may also call the **Mobile Crisis Response** hotline at **1-800-345-9049** TTY/TDD: **711**. This is a 24-hour crisis intervention and stabilization service. During a psychiatric or behavioral health crisis, a qualified mental health professional is dispatched to provide a face-to-face screening.

Some of the behavioral health services we cover include:

- Inpatient Mental Health and Substance Abuse Services
- Intensive Outpatient Services
- Community Based Services
- Mental Health Assessment and/or Psychological Evaluation

- Therapy/Counseling (individual, family, group)
- If you see a provider in the network, you do not need a referral. Services may require prior authorization so call Member Services to check if you are not sure.

### **Chiropractor Services**

Covered services are limited to spinal manipulation for subluxation of the spine for members under 21. If you see an in-network provider, you don't need a referral.

### **Colorectal Cancer Screening**

Colorectal cancer screenings are covered.

### **Diagnostic and Therapeutic Radiology**

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

- Non-invasive X-rays and testing to help find out what is wrong must be ordered and done by (or under the guidance of) your PCP.
- Screening mammograms are not covered until age 40. You may receive one baseline mammogram after you turn 35 years of age.
- CTs and MRIs need an OK from your PCP and the Plan.

### **Doctor Services**

We will pay for your annual adult well exam as well as visits to:

- Your PCP
- Your WHCP
- Your Advanced Practice Nurse
- Visits to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)
- An in-network specialist (with an OK from your PCP)
- Other in-network providers (with an OK from your PCP)

### **Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services**

ESPDT program is covered for members under the age of 21. The program includes:

- Physical exams
- Development screenings
- Lab work
- Immunization
- Health history and education

You do not need an OK from us to receive these services with an in-network provider.

### **Emergency and Urgent Care Services**

If you have a true emergency, call **911** or go to the nearest ER. We do not need to OK hospital emergency and urgent care services. This includes transportation. These services are covered. Read more about what an emergency is on page 10. Call your PCP for follow-up care within two **(2) days** of your emergency, or as soon as you can. You are also required to call Member Services to let the Plan know you received services.

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

You will be seen as soon as possible. You should call your PCP after any emergency (home or away). This is so your PCP can plan your follow-up care. You must also call your care coordinator after an emergency. They need to know an emergency occurred. They will 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.

### **Family Planning Services**

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 in or out of the network.

### **Limits**

Some services are not covered:

- Surgery to reverse sterilization
- Fertility treatments
  - Artificial insemination
  - In vitro fertilization

You can find family planning providers near you at our website. You can also call Member Services for help finding one.

### **Home Health Care Services**

Home health care services need an OK from us. Home health coverage for non-waiver members is limited to those services needed after you are discharged from an in-patient hospital stay. Some services covered at your home include:

- Home health aide services
- Speech therapy
- Physical therapy visits
- Occupational therapy visits
- DME
- Disposable medical supplies

### **Hospice Services (including Palliative)**

This is for members who are not expected to live for more than six months. Services include:

- Medical
- Social
- Support

## Hospital Services

Your PCP can send you to any in-network hospital. Look in the Provider Directory to find one. Go to the nearest hospital in an emergency.

### *Inpatient Hospital Services*

Inpatient hospital services that are covered need an OK from us. Covered services include:

- Rehab services
- Surgery to repair the breast after a complete or partial removal for any medical reason
- Medical stabilization for chemical dependency in a general acute 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 (includes oxygen)
- Giving you donated blood
- Radiation therapy
- Chemotherapy
- Dialysis
- Meals and special diets
- General nursing care
- Anesthesia
- Respiratory therapy
- Diagnostic, therapeutic and rehabilitative services
- Staying in the hospital overnight for dental procedures due to medical problems or serious dental work
- Coordination of discharge planning, including continuing care
- Detoxification

### *Outpatient Hospital Services*

Some covered outpatient hospital services that are covered need an OK from us. Covered services include:

- Dialysis
- Emergency room use
- Physical, occupational or speech therapy
- Audiologists
- Drugs ordered by a doctor
- Giving you donated blood
- Limited oral surgery
- Services to prevent or diagnose problems
- Therapeutic and rehabilitative services
- Ambulatory surgical treatment centers
- Hospital ambulatory services

## **Laboratory and X-ray Services**

These services must be ordered by your provider. They must be done by a licensed provider in an appropriate place.

Covered services include:

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

## **Medical Equipment and Supplies**

Most Medical Equipment and Supplies covered will still need an OK from the Plan. Covered supplies include:

- Prosthetics and Orthotics
- Respiratory Equipment and Supplies

We 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 only for making the room or home comfortable, such as:
  - Air conditioning
  - Air filters
  - Air purifiers
  - Spas/Swimming Pools
  - Elevators
  - Supplies for hygiene or looks

## **Nursing Care Services**

Covered for members under 21 not in the HCBS Waiver. Also covered for individuals who are Medically Fragile Technology Dependent (MFTD) Waiver.

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

These services need an OK from the Plan.

## **Nursing Facilities Services**

A Nursing Facility (NF) sometimes goes by different names 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 services after you have been in the hospital.

These services need an OK from the Plan.

## **Physical Therapy, Occupational Therapy and Speech Pathology**

These services need an OK from the Plan. They are covered when ordered by a doctor and part of a written plan of care.

## **Podiatry (Foot Care)**

These services are 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 those members under 21, additional services include:
- Treatment of flat feet
- Treating the feet when the bones are not in line and surgery is not needed

### ***Limits***

The following 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 are covered for members 40 or older.

## **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 covered services.

Substance abuse treatments we cover include:

- Inpatient treatment
- Outpatient treatment
- Detoxification
- Day treatment
- Rehabilitation
- Medication Assisted Treatment

## **Transplants**

Transplants covered will still need an OK from the Plan. Covered transplants include:

- Lungs
- Combined heart and lung
- Liver
- Kidney
- Cornea
- Stem cell

### ***Limits***

The first transplant is covered. Only one future re-transplant due to rejection is allowed.



# Covered Home and Community Based Services (Waiver clients only)

Here is a list of some of the medical services and benefits that Blue Cross Community Health Plans covers for members who are in a Home and Community Based service waiver.

## **Department on Aging (DoA), *Persons who are Elderly:***

- Adult Day service;
- Adult Day service Transportation;
- Homemaker;
- Personal Emergency Response System (PERS);

## **Department of Rehabilitative Services (DRS), *Persons with Disabilities, HIV/AIDS:***

- Adult Day service;
- Adult Day service Transportation
- Environmental Accessibility Adaptations-Home;
- Home Health Aide;
- Nursing Intermittent;
- Skilled Nursing (RN and LPN);
- Occupational Therapy;
- Home Health Aide;
- Physical Therapy;
- Speech Therapy;
- Homemaker;
- Home Delivered Meals;
- Personal Assistant;
- Personal Emergency Response System (PERS);
- Respite;
- Specialized Medical Equipment and Supplies;

## **Department of Rehabilitative Services (DRS), *Persons with Brain Injury:***

- Adult Day service;
- Adult Day service Transportation;
- Environmental accessibility Adaptations-Home;
- Supported Employment;
- Home Health Aide;
- Nursing, Intermittent;
- Skilled Nursing (RN and LPN);
- Occupational Therapy;
- Physical Therapy;
- Speech Therapy;

- Prevocational Services;
- Habilitation-Day;
- Homemaker;
- Home Delivered Meals;
- Personal Assistant;
- Personal Emergency Response System (PERS);
- Respite;
- Specialized Medical Equipment and Supplies;
- Behavioral Services (M.A. and PH.D.)

**HealthCare and Family Services (HFS), Supportive Living Facility:**

- Assisted Living

## Managed Long Term Support & Services (MLTSS) Covered Services

If you receive Managed Long Term Support & Services, a separate handbook is available. It contains information about supplemental benefits that apply only to MLTSS recipients. If you need a copy of this handbook, please call Member Services.

**MLTSS Covered Services include:**

- Mental health services like: Group and Individual Therapy, Counseling, Community Treatment, Medication Monitoring and more
- Alcohol and substance use services like: Group and Individual therapy, Counseling, Rehabilitation, Methadone services, Medication Monitoring and more
- Some transportation services to appointments
- Long Term Care services in skilled and intermediate facilities
- All Home and Community Based Waiver Services like the ones listed above under ‘Covered HCBS Services’ if you qualify

## Limited Covered Services

- Abortion services where necessary to protect the health or life of the pregnant woman, or in cases of rape or incest.
- Health plan may provide sterilization services only as allowed by State and federal law.
- If Health plan provides a hysterectomy, Health plan shall complete HFS Form 1977 and file the completed form in the Enrollee’s medical record.

## Non-Covered Services

Here is a list of some of the medical services and benefits that Blue Cross Community Health Plans does not cover:

- Medical equipment and supplies that are:
  - Used only for your comfort or hygiene
  - Services that are provided without a required referral or required prior authorization;
  - Used for exercise
  - More than one piece of equipment that does the same thing
  - Supplies for hygiene or looks
- Care you got for health problems that are work related, 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 any of these:
  - Members
  - Families
  - Doctors
  - Other providers
- Any service that is not medically necessary
- Procedures that are new or still are being tested
- Sterilization reversals
- Fertility treatments, such as artificial insemination or in-vitro fertilization
- Drugs that are not approved by the U.S. Food and Drug Administration
- Weight loss drugs or diet aids
- Cosmetic drugs
- Drugs that help to 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.
- Routine physical exams asked for by a job, school, or insurance
- Services provided through local education agencies
- Medical services that you get in a setting for emergency care 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.

For additional information on services, please review your Certificate of Coverage or contact Member Services at **1-877-860-2837** (TTY/TDD **711**). We are available 24 hours a day, seven (7) days a week. The call is free.

## 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 an in-network dental provider, call Member Services or DentaQuest at **1-888-291-3763**.

The plan covers the following dental services:

- Oral exams
- Teeth cleanings
- Fillings
- Crowns
- Limited Root Canals
- Limited Dentures
- Limited Oral Surgery
- Fluoride treatments for children
- Extractions

Some limits apply to general dentistry above.

Eligible pregnant members can get the additional dental services prior to the birth of their babies as below:

- Periodic oral examination
- Teeth cleaning
- Periodontal work

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

### **Are emergency dental services covered?**

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

Prior Authorization may be necessary for the emergency dental services listed above.

## Vision 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 eye exam every 12 months per member
- Glasses are covered every two years for members 21 and older. They are 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.

# Pharmacy Services

## How Do I Get My Prescription?

The Plan uses a Preferred Drug List (PDL). This is to help your doctor choose which drugs to give you. Certain drugs on this list need an OK 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 [www.bcchpil.com](http://www.bcchpil.com).

You will need to get your medication at a network pharmacy. You will receive up to a 30-day supply. You do not have copays on prescriptions filled at in-network pharmacies.

We want to protect your health and keep you safe. Make sure your doctor and pharmacist know what medicines you are taking. This includes over-the-counter drugs.

## Over-The-Counter (OTC) Drugs

Over-the-counter drugs (OTC) 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.

## Mail-Order Program

We offer a mail-order program for chronic disease medicines. You can get up to a 90-day supply sent directly to your home. There is no cost to you. Call Member Services for more information.

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

## 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 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 request.

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 request from your doctor.

## If you need help getting to your pharmacy

Call Member Services if you need help getting to your pharmacy. There is also information on Non-Emergency Transportation on page 20.

# Transportation Services

## Non-Emergency Transportation Services

The Plan offers this service free of charge when you have no other way to get to:

- A doctor's appointment
- An appointment with another health care provider

The Plan does not cover rides:

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

Blue Cross Community Health Plans has partnered with LogistiCare to provide transport services. You can reach them at **1-877-831-3148**, TTY/TDD: **1-866-288-3133**. They are available Monday through Friday, 8:00 am to 6:00 pm, CST.

### To schedule a ride:

Call LogistiCare for a ride at least 72 hours before the appointment. Call **911** for emergency transport only. (You do not need an OK from the Plan for emergency transport.)

### Before your ride:

You should be ready and waiting for your ride one hour before your visit. You are responsible for any medical equipment or safety seat. This includes wheel chairs or car seats for a child.

### When it's time for your ride:

When your driver comes, they will honk, knock, ring the bell, or call you. They must wait 5 minutes for you to come to the vehicle. After 5 minutes, they may leave your location. If so, they will report the trip as a no-show.

Drivers are allowed to transport multiple members on the same ride. This should not add any more than 45 minutes to your travel time.

If your provider does not show up or you feel you may be late to your visit, call Member Services.

### After your visit:

You may pre-schedule a return ride if you know what time you will be done. If you pre-schedule your return ride, the driver should come within 30 minutes.

If you do not have a pre-scheduled pick up time, call Member Services when you are done with your visit and ready for your return ride. The driver should come within an hour of the call.

### Transport services hours of operation:

Monday – Friday

8 a.m. – 6 p.m. Central time

You should call Member Services to file a complaint about your transportation service.

# Added Benefits

## No copays

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

## Prescriptions

- 90-day supply of chronic disease drugs mailed to your home

## Dental

Blue Cross Community Health Plans also covers:

- Two Cleanings per year
- Two Exams per year
- One set of preventive X-rays per year
- Extra dental care for adults
- Practice visits: Members with developmental disabilities or serious mental illness can go for practice visits to the dentist

## Cell Phone

A free cell phone to call your doctor, care coordinator or 9-1-1 emergency services

## Transportation

You may also get transportation to the pharmacy after a provider appointment. This is in addition to the standard transportation benefit.

## Optical (Vision)

You can get \$40 toward a pair of upgraded eyeglass frames two years

## Healthy Incentives

Some preventative care actions have incentives available to members when they are completed. Listed below are some incentives you may qualify for:

- **Pregnancy and healthy kids**

Pregnant members who join Special Beginnings will receive education and support to guide them through pregnancy and delivery. You may also qualify for a free car seat, portable crib or diapers in the Special Beginnings program. If you are pregnant, or thinking of becoming pregnant and would like to enroll in Special Beginnings, please call Member Services.

- **Wellness**

You may qualify for:

- Gift cards for completing certain preventive services in the Healthy Behaviors program
- Members with diabetes can get in-home blood sugar test kits

## Care Coordination

Members will complete a Health Risk Screening (HRS) at least annually. The HRS helps us determine if you will need a care coordinator. If so, we will assign you a care coordinator. They will be your health care “coach”. They will oversee the Plan of care you and your Care Team decide is right. Care coordinators can help you reach your health goals using your benefits.

Your care coordinator will also:

- Plan in-person visits or phone calls with you
- Listen to your concerns
- Help you get services and find health issues before they get worse (preventive care)
- Help set up care with your doctor and other health care team members
- Help you, your family and your caregiver better understand your health condition(s), medications and treatments

If you did not receive a HRS and would like to complete one, please call Member Services.

## Disease/Health Education Management Programs

Each person has special needs at every stage of life. We have programs to help you stay healthy and to manage illness.

Below is a list of yearly recommended preventive exams. You should review this with your PCP.

If You Are	You Need
Age 19-20	Annual Physical Exam, Annual Flu Shot, Tetanus-Diphtheria Booster (needed every 10 years), Additional Immunizations as recommended by your PCP
Age 21-34	Annual Physical Exam, Annual Flu Shot, Tetanus-Diphtheria Booster (needed every 10 years) Pap Smear, Chlamydia Screening, HPV Vaccine (if you are under 26)
Age 35-49	Annual Physical Exam, Annual Flu Shot, Tetanus-Diphtheria Booster (needed every 10 years), Pap Smear, Cholesterol Testing (if you are over 44), Glaucoma Screening (if you are over 39) Baseline Mammogram (covered once for members age 35-40), Annual Screening Mammogram for members 40 or older
Age 50-64	Annual Physical Exam, Annual Flu Shot, Tetanus-Diphtheria Booster (needed every 10 years), Pap Smear, Mammogram, Cholesterol Testing, Colorectal Cancer Screening, Glaucoma Screening
Age 65+	Annual Physical Exam, Annual Flu Shot, Tetanus-Diphtheria Booster (needed every 10 years), Pneumococcal Vaccine, Mammogram (to age 74), Cholesterol Testing, Colorectal Cancer Screening (to age 75), Glaucoma Screening, Hearing Screening



You can use these programs and get information about them at no cost. Call Member Services to learn more about these programs. You can also check out our website. Look under the Member Resources at [www.bcchpil.com](http://www.bcchpil.com). If you have hearing or speech loss, call the Member Services TTY/TDD line.

We hope you use them. We want you to be well and to stay that way.

## Healthy Living

Your care coordinator and Care Team will help you get the information and care you need to be healthy. And they will assist in managing your health condition. This includes:

- Tips on how to help manage your weight, eat better and stay fit with an exercise program
- Brochures with heart-healthy tips on how to help control blood pressure and cholesterol
- Brochures on drugs and alcohol show you how to stop problems before they start
- Well care with tips about healthy behaviors and the need for routine exams, mammograms and cancer screenings
- Information about managing on-going medical conditions such as asthma, diabetes, and heart disease
- Family planning to help teach you:
  - How to be as healthy as you can before you get pregnant
  - How to prevent pregnancy
  - How to prevent sexually transmitted diseases (STDs) such as HIV/AIDS

## Blue365®

Blue365 allows members and their covered dependents to save money on value-added health care products and services not usually covered by a member's benefit plan. Medical members and covered dependents have access to a range of discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and much more. There are no claims to file, no referrals, and no additional fees to participate. For more information, visit [www.blue365deals.com](http://www.blue365deals.com).

## WIC

This is a supplemental nutrition program. It is for people who are pregnant, breastfeeding, or have just had a baby within the last six months. It also covers infants and children under the age of five.

Chicago WIC Services

[www.cityofchicago.org/city/en/depts/cdph/provdrs/health\\_promotion/svcs/apply\\_for\\_wic.html](http://www.cityofchicago.org/city/en/depts/cdph/provdrs/health_promotion/svcs/apply_for_wic.html)

Illinois WIC Services

[www.dhs.state.il.us/page.aspx?item=30513](http://www.dhs.state.il.us/page.aspx?item=30513)

## Parenting

Healthy Families Illinois - a home visit program to help new parents -

[www.dhs.state.il.us/page.aspx?item=31780](http://www.dhs.state.il.us/page.aspx?item=31780)

## Parents Care and Share

A support groups for dads, grandparents, children, peer groups, and leadership development. Contact Children's Home and Aid Society at **1-312-424-0200**.

## Family Case Management

Case management for the entire family - [www.dhs.state.il.us/page.aspx?item=30517](http://www.dhs.state.il.us/page.aspx?item=30517)

## For Your Peace of Mind

24/7 Nurseline lets you talk in private with a nurse about your health. Call toll-free, 24 hours a day, seven (7) days a week at **1-888-343-2697**. A nurse can give you details about health issues and community health services.

You can also listen to audio tapes on more than 300 health topics such as:

- Allergies and Immune System
- Children's Health
- Diabetes
- High blood pressure
- Sexually transmitted diseases such as HIV/AIDS

## The Ombudsman Program

### 1. The Blue Cross Blue Shield Ombudsman Program

The Blue Cross Blue Shield Ombudsman Program is a resource that addresses questions or concerns regarding access to member benefits. We host our Member Advisory Board meeting quarterly in every county in which BCBS services. It is an opportunity for our members to provide feedback to our team on how member benefits are working. Members can attend these meetings in person or by phone.

Members can also take part in our **Medicaid 101 course** for our newly enrolled members to help better understand their benefits and how to navigate them. In addition, we host a Family Leadership Council twice a year.

If members are interested in these programs or meetings, contact our ombudsman program to learn more:

<b>CALL</b>	1-888-775-6875
<b>EMAIL:</b>	ILmedicaidoperations@bcbsil.com

### 2. 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.

<b>MAIL:</b>	aging.ilsenior@illinois.gov
<b>WEBSITE</b>	<a href="http://www.state.il.us/aging/1abuselegal/ombuds.htm">www.state.il.us/aging/1abuselegal/ombuds.htm</a>
<b>CALL:</b>	1-800-252-8966 1-888-206-1327
<b>WRITE:</b>	Long-Term Care Ombudsman Program Illinois Department on Aging One Natural Resources Way, Suite 100 Springfield, IL 62702-1271

## Recipient Restriction Program

Blue Cross Community Health Plans monitors prescription drug use. This is part of our Recipient Restriction Program.

We look for warning signs such as:

- Drug therapy duplication
- Over- and under-use of drugs
- Overlapping pharmacies or prescribers
- Drug misuse or abuse

Our pharmacy team uses a set “lock-in” process. This is used to address drug abuse or misuse. This involves limiting (“locking”) members to one pharmacy during their treatment.

## Advance Directives

An advance directive is a written decision you make about your health care in the future in case you are so sick you can't make a decision at that time. In Illinois, there are four types of advance directives:

- **Healthcare Power of Attorney**- This lets you pick someone to make your health care decisions if you are too sick to decide for yourself.
- **Living Will**- This tells your doctor and other providers what type of care you want if you are terminally ill which means you will not get better.
- **Mental health Preference**- This lets you decide if you want to receive some types of mental health treatments that might be able to help you.
- **Do Not Resuscitate (DNR) order**- This tells your family and all your doctors and other providers what you want to do in case your heart or breathing stops.

You can get more information on advance directives from your health Plan or your doctor. If you are admitted to the hospital they might ask you if you have one. You do not have to have one. You do not have to have one to get your medical care but most hospitals encourage you to have one. You can choose to have any one or more of these advance directives if you want and you can cancel or change it at any time.

# Grievance & Appeals

## Grievances

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

Blue Cross Community Health Plans 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 Health Plans 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 Health Plans 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 Health Plans staff member was rude to you.
- Your provider or a Blue Cross Community Health Plans 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 at 1-877-860-2837 (TTY/TDD: 711). You can also file your grievance in writing via mail or fax at:

Blue Cross Community Health Plans  
Attn: Grievance and Appeals Dept.  
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, the 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 Health Plans in writing 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

An appeal is a way for you to ask for a review of our actions. 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

You may not agree with a decision or an action made by Blue Cross Community Health Plans 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 **sixty (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 **ten (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

### Here are two ways to file an appeal.

- 1) 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.
- 2) Mail or fax your written appeal request to:

Blue Cross Community Health Plans  
Attn: Grievance and Appeals Dept.  
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 Primary Care Physician 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 contact 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 us 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.bcchpil.com](http://www.bcchpil.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 Health Plans will send our decision in writing to you within fifteen (15) business days of the date we received your appeal request. Blue Cross Community Health Plans may request an extension up to fourteen (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 you 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 Health Plans' 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 Health Plans' 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 Health Plans reviews your appeal.

## How can you expedite your Appeal?

If you or your provider believes our standard timeframe of fifteen (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 twenty-four (24) hours if we need more information. Once all information is provided, we will call you within twenty-four (24) hours to inform you of our decision and will also send you and your authorized representative the Decision Notice.

## 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 as 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.

Blue Cross Community Health Plans 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 Health Plans at 1-877-860-2837 (TTY/TDD: 711).

## What happens next?

After you receive the Blue Cross Community Health Plans 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 **thirty (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 **one hundred-twenty (120) 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 these services provided to you during the appeal process.

At the State Fair Hearing, just like during the Blue Cross Community Health Plans 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.
- Visit <https://abe.illinois.gov/abe/access/appeals> to set up an ABE Appeals Account and submit a State Fair Health Appeal online. This will allow you to track and manage your appeal online, viewing important dates and notices related to the State Fair Hearing and submitting documentation.
- 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) 793-2005  
Email: HFS.FairHearings@illinois.gov  
Or you may call (855) 418-4421, TTY: (800) 526-5812

- If you want to file a State Fair Hearing Appeal related to mental health services or items, substance abuse services, Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver services, HIV/AIDS Waiver services, or any Home Services Program (HSP) service, send your request in writing to:

Illinois Department of Human Services  
Bureau of Hearings

69 W. Washington Street, 4th Floor  
Chicago, IL 60602

Fax: (312) 793-8573

Email: [DHS.HSPApeals@illinois.gov](mailto:DHS.HSPApeals@illinois.gov)

Or you may call (800) 435-0774, TTY: (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. If you set up an account at <http://abe.illinois.gov/abe/access/appeals> you can access all letters related to your State Fair Hearing process through your ABE Appeals Account. You can also upload documents and view appointments.

At least three (3) business days before the hearing, you will receive information from Blue Cross Community Health Plans. 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 Health Plans 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.

## 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 **ten (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. The Decision will also be available online through your ABE Appeals Account. 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 thirty-five (35) days from the date of this letter. If you have questions, please call the Hearing Office.

## **External Review (for medical services only)**

Within **thirty (30) calendar days** after the date on the Blue Cross Community Health Plans appeal Decision Notice, you may choose to ask for a review by someone outside of Blue Cross Community Health Plans. 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

External Review is not available for appeals related to services received through the Elderly Waiver; Persons with Disabilities Waiver; Traumatic Brain Injury Waiver; HIV/Aids Waiver; or the Home Services Program.

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

Blue Cross Community Health Plans  
Attn: Grievance and Appeals Dept.  
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 Health Plans 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.

Blue Cross Community Health Plans  
Attn: Grievance and Appeals Dept.  
P.O. Box 27838  
Albuquerque, NM 87125-9705

## 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 Health Plans know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Blue Cross Community Health Plans with the decision within forty-eight (48) hours.

# Rights & Responsibilities

## Your rights

- Be treated with respect and dignity at all times.
- Have your personal health information and medical records kept private except where allowed by law.
- Be protected from discrimination.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Receive information from Blue Cross Community Health Plans in other languages or formats such as with an interpreter or Braille.
- Receive information on available treatment options and alternatives.
- Receive information necessary to be involved in making decisions about your healthcare treatment and choices.
- Refuse treatment and be told what may happen to your health if you do.
- Receive a copy of your medical records and in some cases request that they be amended or corrected.
- Choose your own primary care provider (PCP) from the Blue Cross Community Health Plans. You can change your PCP at any time.
- File a complaint (sometimes called a grievance), or appeal without fear of mistreatment or backlash of any kind.
- Request and receive in a reasonable amount of time, information about your Health Plan, its providers and policies.

## Your responsibilities

- Treat your doctor and the office staff with courtesy and respect.
- Carry your Blue Cross Community Health Plans ID card with you when you go to your doctor appointments and to the pharmacy to pick up your prescriptions.
- Keep your appointments and be on time for them.
- If you cannot keep your appointments cancel them in advance.
- Follow the instructions and treatment plan you get from your doctor.
- Tell your health plan and your caseworker if your address or phone number changes.
- Read your member handbook so you know what services are covered and if there are any special rules.

# Fraud, Abuse and Neglect

Fraud, Abuse and Neglect are all incidents that need to be reported.

Fraud occurs when someone receives benefits or payments they are not entitled to. Some other examples of fraud are:

- To use someone else's ID card or let them use yours.
- A provider billing for services that you did not receive.

Abuse is when someone causes physical or mental harm or injury. Here are some examples of abuse:

- Physical abuse is when you are harmed such as slapped, punched, pushed or threatened with a weapon.
- Mental abuse is when someone uses threatening words at you, tries to control your social activity, or keep you isolated.
- Financial abuse is when someone uses your money, personal checks or credit cards without your permission.
- Sexual abuse is when someone is touching you inappropriately and without your permission.

Neglect occurs when someone decides to hold the basic necessities of life such as food, clothing, shelter or medical care.

## If You Suspect Abuse, Report It

By law, it is your responsibility to report allegations of abuse and neglect. You should contact 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 or neglect is an adult 18 years and older who is not in a nursing home or a supported living facility call DOA's Hotline at **1-866-800-1409**. TTY: **1-800-358-5117**

You can also report any suspected areas of fraud or abuse to us. Please call Blue Cross Community Health Plans 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.

## Privacy Policy

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 Service.

# Definitions

**Appeal** means a request for your health plan to review a decision again.

**Co-payment** means a fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

**Durable Medical Equipment** means equipment and supplies ordered by a health care provider for everyday or extended use.

**Emergency Medical Condition** means an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

**Emergency Services** means the evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

**Excluded Services** means health care services that your health insurance or plan doesn't pay for or cover.

**Grievance** means a complaint that you communicate to your health plan.

**Habilitation Services and Devices** means services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Home Health Care** means health care services a person receives at home.

**Hospice Services** means services to provide comfort and support for persons in the last stages of a terminal illness and their families.

**Hospitalization** means care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

**Hospital Outpatient Care** means care in a hospital that usually doesn't require an overnight stay.

**Medically Necessary** means Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

**Out of Network** means providing a beneficiary with the option to access plan services outside of the plan's contracted network of providers. In some cases, a beneficiary's out-of-pocket costs may be higher for an out-of-network benefit.

**Prior Authorization** means a decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. It is sometimes called pre-authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

**Prescription Drug Coverage** means health insurance or plan that helps pay for prescription drugs and medications.

**Primary Care Provider** means a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

**Rehabilitation Services and Devices** means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

**Skilled Nursing Care** means nursing services provided within the scope of the Illinois Nurse Practice Act (225 ILCS 65/50-1 et seq.) by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.

**Specialist** means a physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

**Urgent Care** means care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

## Disclaimers

Davis Vision is an independent company that provides vision care benefits for some Blue Cross and Blue Shield of Illinois plans.

DentaQuest is an independent company that provides dental benefits for Blue Cross and Blue Shield of Illinois

LogistiCare is an independent contractor that arranges and manages non-emergency transportation benefits for select Blue Cross and Blue Shield of Illinois plans

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association





To ask for supportive aids and services, or materials in other formats and languages for free, please call,  
1-877-860-2837 TTY/TDD:711.

Blue Cross and Blue Shield of Illinois complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Illinois:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Illinois has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35<sup>th</sup> floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, [Civilrightscoordinator@hcsc.net](mailto:Civilrightscoordinator@hcsc.net). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**English:** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-860-2837 (TTY/TDD: 711)**.

**Español (Spanish):** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-860-2837 (TTY/TDD: 711)**.

**繁體中文 (Chinese):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-860-2837 (TTY/TDD: 711)**。

**Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-860-2837 (TTY/TDD: 711)**.

**Français (French):** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-860-2837 (ATS : 711)**.

**Tiếng Việt (Vietnamese):** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-860-2837 (TTY/TDD: 711)**.

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-860-2837 (TTY/TDD: 711)**.

**한국어 (Korean):** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-860-2837 (TTY/TDD: 711)**번으로 전화해 주십시오.

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-860-2837 (телетайп: 711)**.

**العربية (Arabic):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-7382-068-778 (رقم هاتف الصم والبكم: 117).

**हिंदी (Hindi):** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-860-2837 (TTY/TDD: 711)** पर कॉल करें।

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-860-2837 (TTY/TDD: 711)**.

**ગુજરાતી (Gujarati):** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-860-2837 (TTY/TDD: 711)**.

**Urdu (Urdu):** کریں کال - ہیں دستیاب میں مفت خدمات کی مدد کی زبان کو آپ تو، ہیں بولتے اردو آپ اگر: خبردار **1-877-860-2837 (TTY/TDD: 711)**.

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-860-2837 (TTY/TDD: 711)**.

**λληνικά (Greek):** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-860-2837 (TTY/TDD: 711)**.







**BlueCross BlueShield  
of Illinois**