



**Managed Long-Term Supports
and Services (MLTSS)
Certificate of Coverage**
www.bcchpil.com

Effective January

2020

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 24 hours a day, seven (7) days a week. The call is free.



Website

www.bcchpil.com



Write

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

Important Phone Numbers

24/7 Nurseline – 24-hour-a-day help line	1-888-343-2697, TTY/TDD: 711
Emergency Care	911
Blue Cross Community Health Plans Member Services We are available 24 hours a day, seven (7) days a week. The call is free. Website: www.bcchpil.com Service Area: The plan covers members who live in the state of Illinois.	1-877-860-2837, TTY/TDD: 711
Blue Cross Community Health Plans Special Investigation Department (SID)	1-800-543-0867
National Poison Control Center Calls are routed to the office closest to you.	1-800-222-1222
Non-Emergency Medical Transportation	1-877-831-3148, TTY/TDD: 1-866-288-3133
Behavioral Health Services	1-877-860-2837, TTY/TDD: 711
Mobile Crisis Response	1-800-345-9049, TTY/TDD: 711
Grievances and Appeals	1-877-860-2837, TTY/TDD: 711
Fraud and Abuse	1-800-543-0867, TTY/TDD: 711
Care Coordination	1-855-334-4780, 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

MLTSS Certificate of Coverage

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MLTSS Certificate of Coverage

Blue Cross Community Health Plans, also known as “The Plan” or BCCHP, has contracted with the Illinois Department of Healthcare and Family Services (HFS) to provide health care coverage for the Managed Long-Term Services and Supports (MLTSS) program for seniors and persons with disabilities.

The Plan and this Certificate are provided by Blue Cross and Blue Shield of Illinois, operating as a health maintenance organization. Blue Cross Community Health Plans is located at 300 E. Randolph Street, Chicago, Illinois 60601.

In consideration of the member’s enrollment, Blue Cross and Blue Shield of Illinois shall provide and/or arrange for covered health care services to the member in accordance with the provisions of this Certificate of Coverage. A description of covered health care services is available in the Blue Cross Community Health Plans Member Handbook and in this document.

This Certificate of Coverage may be subject to amendment, modification, or termination by mutual agreement between Blue Cross Community Health Plans, an Illinois plan (‘The Plan’) or BCCHP and the Illinois Department of Healthcare and Family Services (‘Department’) without the consent of any member. Members will be notified of any such changes as soon as possible after they are made.

By choosing or accepting health care coverage under Blue Cross and Blue Shield of Illinois, an Illinois corporation, members agree to all the terms and conditions in this Certificate of Coverage.

The effective date of coverage under this Plan is stated on your member ID card that was mailed to you previously.

Service Area

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

Care while traveling

For medical coverage while traveling, please call the customer service number on your Medicare or Medicare Advantage Plan, Medicaid and your Prescription Drug (Medicare Part-D) Plan ID card.

Care outside the United States

The Plan does not cover services outside the United States.

Please send general correspondence to:

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

Description of Coverage Worksheet

Blue Cross Community Health Plans

300 E. Randolph Street

Chicago, Illinois 60601

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

www.bcchpil.com

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

Deductibles and Copays

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

Medical Services	Blue Cross Community Health Plans Benefit Limit/Exclusions	Provider Must Obtain Prior Authorization
Behavioral Health Services		You may need a prior authorization from us before you get covered services.
Environmental Home Adaptations	These services are covered as part of the written plan of care.	Yes
Nursing Care Services	A written order from a physician may be required before getting nursing care services.	Yes
Nursing Facility Services		Yes
Non-Emergency Transportation Services	Call Member Services for a ride at least 72 hours before the appointment. You are responsible for any medical equipment or safety seat. This includes wheel chairs or car seats for a child.	

Covered Home and Community Based Services (Waiver clients only)

HCBS Waiver Program	Services	Provider Must Obtain Prior Authorization
Department on Aging (DoA), Persons who are Elderly:	<ul style="list-style-type: none"> • Adult Day service; • Adult Day service Transportation; • Homemaker; • Personal Emergency Response System (PERS); 	You may need a prior authorization from us before you get covered services.
Department of Rehabilitative Services (DRS), Persons with Disabilities, HIV/AIDS	<ul style="list-style-type: none"> • 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; 	You may need a prior authorization from us before you get covered services.
Department of Rehabilitative Services (DRS), Persons with Brain Injury:	<ul style="list-style-type: none"> • 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.) 	You may need a prior authorization from us before you get covered services.
HealthCare and Family Services (HFS), Supportive Living Facility	<ul style="list-style-type: none"> • Assisted Living 	You may need a prior authorization from us before you get covered services.

Added Benefits

No copays

You pay \$0 for covered standard Medicaid services covered by BCCHP.

Cell Phone

You may qualify for a free cell phone to call your doctor, care coordinator, or **911** emergency services

Transportation

In addition to the standard benefit of transportation to covered services, you may also get transportation to the pharmacy after a provider appointment.

Meal Benefits

As You may be eligible for up to 10 meals after being released from the hospital. The meals will need an OK from BCCHP.

Over-the-Counter Drugs and Supplies

Over-the-counter drugs (OTC) are medicines you can buy at the pharmacy without a prescription. As a member of the Plan, you can get Plan-approved Over-the-Counter (OTC) items one time every quarter at no cost to you. Your order will be shipped to your address within 7 to 10 days.

The Plan will pay up to a \$40 benefit per quarter. Only one order can be placed in each quarter. The benefit amount will not roll over to the next quarter. If you do not use the full dollar amount, you will lose the remaining balance. To place an order you can call Member Services at **1-877-860-2837** (TTY/TDD: **711**).

Non-Covered Services

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

- Doctor Services
 - Specialty services
 - PCP services
- Inpatient and Outpatient Hospital Services
- Prescriptions
- 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
- Procedures that are new or still are being tested

- Services that are provided by a non-Network Provider and not authorized by your Health Plan
- Services that are provided without a required referral or required prior authorization;
- Sterilization reversals
- Fertility treatments, such as artificial insemination or in-vitro fertilization
- 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
- Routine physical exams asked for by a job, school, or insurance
- Medical services that you get in a setting for emergency care for health issues that are not emergencies
- Abortion
- Annual Adult Well Exams
- Audiology Services
- Chiropractor Services
- Colorectal Cancer Screening
- Dental Services
- Diagnostic and Therapeutic Radiology
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services
- Emergency and Urgent Care Services
- Family Planning Services
- Laboratory and X-ray Services
- Medical Equipment and Supplies
- Podiatry (Foot Care)
- Prostate and Rectal Exams
- Transplants
- Vision Services
- Optical (Vision)

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.

Prior Authorization (Getting an OK from the Plan)

Your PCP will get an OK from BCCHP for some services. This is to make sure they are covered. This means that both BCCHP 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
- Help in finding out what’s wrong or treating the disease, illness or injury
- Help you do things like eating, dressing and bathing

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 BCCHP network if you didn’t get an OK from us before getting the services.

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

Please call your PCP for urgent care or you can call the customer service number on the back of your health insurance ID card.

Blue Cross Community Health Plans covers your long-term services and supports. For medical and prescription drug coverage, please contact your Medicare or Medicare Advantage Plan, Medicaid or your Prescription Drug (Medicare Part-D) Plan.

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 having 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

Blue Cross Community Health Plans covers your long-term services and supports. For medical and prescription drug coverage, please contact your Medicare or Medicare Advantage Plan, Medicaid or your Prescription Drug (Medicare Part-D) Plan.

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.

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
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, regardless of cost or benefit coverage.
- 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.
- To make recommendations regarding the organization's member rights and responsibility policy.
- 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 and agree with goals to provide better care for your health.
- Tell your health plan and your caseworker if your address or phone number or any other information changes to provide care efficiently.
- Understand your health status and participate in developing mutually agreed-upon treatment goals to the degree possible.
- 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.

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., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hsc.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>.



**BlueCross BlueShield
of Illinois**