



Managed Long Term Supports and Services (MLTSS) Member Handbook

Effective Date: 01/21/2020

Member Services: 1-877-860-2837

(TTY/TDD: 711)

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, also known as “the Plan”
- 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
- Grievance & 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

Keep your Blue Cross Community Health Plans identification card (ID) with you at all times, along with any other insurance cards you may have like your Illinois Department of Healthcare and Family Services (HFS) medical card, and any Medicare cards. Show your Blue Cross Community Health Plans ID card every time you need covered Blue Cross Community Health Plans services. Do not let anyone else use your card.

If it is 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.

If you have a health problem, you can call our 24/7 Nurseline at 1-888-343-2697. Have your Blue Cross Community Health Plans ID card ready when you call.

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.

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

Your Plan Membership

Service Area

BCCHP 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

BCCHP does not cover services outside the United States

Help in Other Languages

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

BCCHP 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?

If you need help in a language other than English (that your provider does not speak) when you are receiving services, you can ask for a face-to-face or phone interpreter at no charge.

BCCHP's Provider Directory tells you what languages the providers speak.

Who do I call for an interpreter?

Call Member Services and we will get someone who speaks your language.

How far in advance do I need to call?

If you need someone to translate for you while you're receiving services in your home or at a facility, 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 PlansSM

Intro to Plan:

Thank you for becoming a member of Blue Cross Community Health Plans, also known as 'BCCHP,' from Blue Cross and Blue Shield of Illinois (BCBSIL), to cover your MLTSS services. MLTSS stands for Managed Long Term Supports and Services. It is a benefit group for managing long-term care services. Long-term care includes help doing everyday things you are no longer able to do for yourself. These services are also called Activities of Daily Living, or ADL. They include things such as bathing, getting dressed, making meals, getting around your home, or doing household chores. Long-term care can be given in your home or in a supportive living facility. These services are meant to keep you living as independently as possible for as long as possible.

Long-term care can be provided in a nursing home. When you get these services in your home or in a community setting they are called Home and Community Based services. You might also see these referred to as HCBS.

MLTSS services you get in your home or in the community from BCCHP will NOT take the place of the care you get from your Primary Care Provider (PCP), your dentist, eye doctor, or any service you get at the hospital or pharmacy. If you get these services and they are paid for by Medicaid, Medicare or other insurance, these services will NOT be replaced by the care Blue Cross Community Health Plans provides. Blue Cross Community Health Plans will work together with your other plans and service providers. This is why it is very important that you keep your care coordinator informed of your medical condition.

Eligibility:

You are an adult or adult with disabilities, age 21 and over. You are eligible for Medicare and Medicaid. You'll receive your Medicaid waiver services through BCCHP, along with a few extra benefits, but you have chosen to use another health plan for services such as preventive care, specialty care, emergency care and inpatient care.

You must have a Determination of Need (DON) score of 29 or higher. A care manager from a State of Illinois agency will conduct the DON in your home. You will be asked about your ability to complete daily activities, like:

- Eating or preparing meals
- Bathing, grooming or dressing Managing Money
- Laundry and Housework

These are just a few examples of the activities considered to determine your need for additional assistance. The DON produces a score from 0 to 100. The higher the score, the higher the demonstrated need.

Blue Cross Community Health Plans does not conduct the DON. This is done by staff of the Illinois Care Coordination Units or the Division of Rehabilitation Services. We will work with these agencies for your annual reassessment, or whenever there is a change in your condition or needs.

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
Illinois Department of Public Health	1-217-782-4977

Blue Cross Community Health Plans

Managed Long Term Supports and Services (MLTSS) Member Handbook

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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:**
 - MLTSS Eligibility
 - MLTSS Covered/Non-Covered Services
 - Care Coordination
 - Urgent and Emergency Care
 - Transportation Services
 - Grievance and Appeals
 - Rights and Responsibilities

Member Identification (ID) Card

You will receive a Member ID Card. You should always carry your card with you. It has important phone numbers.

Information on your Member ID Card:

- Name
- Plan Name
- State Medicaid ID #
- Effective Date
- Member Services # and TTY/TDD line
- 24/7 Nurseline
- 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 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**.

Upon enrollment, you will work with a care coordinator to transition your care. For members who are new to the Managed Long Term Supports and Services program, there will be a 180-day transition period. For members who switch to Blue Cross Community MLTSS from another plan, there will be a 90-day transition period. Your care coordinator will work with you to transition any LTSS services to an in-network provider, if necessary.

Provider Network

The Blue Cross Community Health Plans network is made up of providers and facilities who specialize in long-term supports and services (LTSS). These providers are contracted with Blue Cross and Blue Shield of Illinois (BCBSIL) to provide LTSS to you.

You should use in-network providers. If you choose to see a provider who is not part of our network, you will have to pay for the services. Your PCP and care coordinator will help you locate in-network providers.

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

Primary Care Provider (PCP)

A 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.

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.

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.

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 can help arrange your specialty care.

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.

Blue Cross Community Health Plans covers your long-term support services. For medical services provided by a PCP or a specialist, please contact your Medicare or Medicare Advantage Plan, Medicaid and your Prescription Drug (Medicare Part-D) Plan.

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

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.

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 Opinion

How can I ask for a second opinion?

A second opinion is when you want to see a second provider for the same health concern. You can get a second opinion from a network provider for any of your covered benefits. This is your choice. You are not required to get a second opinion. If the type of provider needed is not available in-network for a second opinion, we will arrange for a second opinion out-of-network at no cost to you.

Prior authorization may be needed.

Call Member Services at **1-877-860-2837** (TTY/TDD: 711) for help getting a second opinion.

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.

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 themselves 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.

Managed Long Term Support & Services (MLTSS) Covered 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.

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 BCCHP covers.

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

Behavioral Health Services

If you have a behavioral health crisis, call **1-877-860-2837** (TTY/TDD: **711**) and 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:

- Community-based alcohol or drug treatments
- Community-based behavioral health services
- Behavioral Health Mobile Crisis Response services

Environmental Home Adaptations

These services are covered as part of the written plan of care and need an OK from BCCHP.

Nursing Care Services

These services focus on members' long-term needs rather than short-term acute care. Members who qualify for Disabilities, HIV/AIDS, or Traumatic Brain Injury waiver services are eligible for nursing care services.

Based on an evaluation done by the State, the care coordinator will write a Care Plan to incorporate nursing care services. This is care given by a registered nurse (RN), or a licensed practical nurse (LPN) who is registered

to practice in the state of Illinois. A written order from a physician may be required before getting nursing care services.

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 BCCHP.

Physical Therapy, Occupational Therapy and Speech Pathology

These services not covered under MLTSS.

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:

- Outpatient services
- Medication Assisted Treatment
- Residential Treatment Detoxification

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

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
- 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.

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

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**).

Cell Phone

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

Transportation

You may also get transportation to the pharmacy after a provider appointment and/or to Blue Cross Community Health Plans sponsored events. This is in addition to the standard transportation benefit. Additional information for the standard transportation benefit can be found on Page 10.

Optical (Vision)

You can get \$40 toward a pair of upgraded eyeglass frames every 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:

- **Extra Help for Pregnant Women**

Pregnant members who join Special Beginnings will receive education and support to guide them through pregnancy and delivery. You may also qualify for:

- Free car seat
- Free portable crib
- Two free packages of diapers after 6-week post-partum doctor's visit

If you are pregnant or thinking of becoming pregnant and would like to enroll in Special Beginnings, please call Member Services.

- **Wellness**

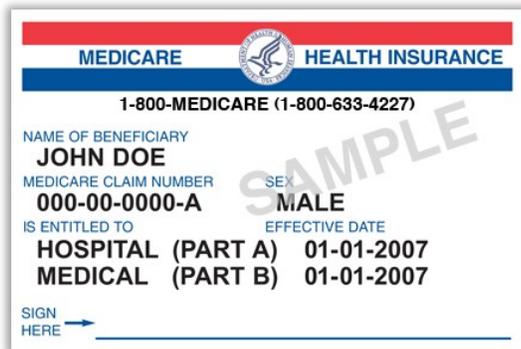
You may qualify for:

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

How to Get Services Not Covered under BCCHP's MLTSS plan?

In addition to your MLTSS coverage, you may have to work with your Medicare or Medicare Advantage Plan, Medicaid and your Prescription Drug (Medicare Part-D) Plan to get services not covered by Blue Cross Community Health Plans. We have supplied other information on how to help you choose a PCP, get services, and file a complaint and/or appeal depending on the type of coverage you have.

Traditional Medicare Coverage



Medical Coverage

Part A:

- Hospital Care
- Skilled Nursing Care
- Nursing Home Care (not custodial care)
- Hospice
- Home Health Services

Part B:

- Doctor's visits
- Preventative Care
- Outpatient Care
- Emergency Room
- Clinical Research
- Ambulance Service or Emergency Ground Transportation
- Durable Medical Equipment (DME)
- Mental Health
 - Inpatient
 - Outpatient
 - Partial Hospitalization
- Getting a second opinion prior to surgery
- Limited Outpatient Prescription Drugs

Who do I call if I want to?

Select a PCP: With this coverage, you can go to any doctor who takes Medicare patients. You have a couple of options to find out what doctors will take your Medicare coverage.

You can call **1-800-699-4227** (TTY: **1-877-486-2048**), and ask what providers are in your area.

You can also use the Physician Compare tool at www.medicare.gov to help you find a doctor who takes Medicare assignment. It is a good idea to call the doctor's office and make sure that he or she will take new Medicare patients before you make an appointment. If you need help, your care coordinator can help you find a PCP.

Access pharmacy benefits: Go to your Medicare Part-D card and call the number on the back to verify what benefits you get through your specific plan.

You can also go to: www.medicare.gov/part-d in order to see what drugs are covered under different Part-D plans. Your care coordinator can help you understand and access your pharmacy benefits.

Access your Medicare covered services: Talk with your PCP, or your care coordinator, and he or she will be able to walk you through these benefits. Your care coordinator can also help you schedule appointments for health services.

File a complaint (grievance) about one or more of your Medicare covered services:

Call **1-800-633-4227** (TTY: **1-877-486-2048**).

You can also visit www.medicare.gov/claims-and-appeals/file-a-complaint/complaint.html or you can call your Senior Health Insurance Program (SHIP) for help at no cost to you. The number to the Illinois SHIP line is **1-800-548-9034** (TTY: **1-866-323-5321**).

You can also contact the Long-Term Care Ombudsman Program Illinois Department on Aging at **1-800-252-8966** (TTY: **1-888-206-1327**) or:

One Natural Resources Way, Suite 100
Springfield, IL 62702-1271

Traditional Medicaid Services (not MLTSS)



As a member eligible for Medicare and Medicaid, remember Medicare is always the first payer of services.

The following are additional services covered by Medicare or Medicaid:

- Early and periodic screening, diagnostic, and treatment services
- Nursing facility services
- Physician services
- Rural health clinic services
- Federally Qualified Health Center (FQHC) services
- Lab and X-rays
- Family planning
- Nurse Midwife services
- Pediatric and Family Nurse Practitioner
- Freestanding birth center services
- Tobacco cessation/counseling for expecting mothers
- Dental services such as dentures
- Vision care
- Clinic services
- Respiratory care
- Prescription drugs covered by Medicaid

Who do I talk to if I want to?

Access pharmacy benefits: Your care coordination can help you understand and access your pharmacy benefits. Reference your Medicare Part-D card and call the number on the back to find out what benefits you get through your plan.

You can also call HFS at **1-800-843-6154** (TTY: **1-800-447-6404**) or visit www.dhs.state.il.us to check your Medicaid prescription drug benefits.

Access your Medicaid covered services: Talk with your PCP or your care coordinator, and he or she will be able to walk you through the Medicaid covered services. Your care coordinator can also help you schedule appointments. As a reminder, Medicare is your primary medical insurance coverage for health services.

File a complaint (grievance) about one or more of your Medicaid covered services: Call the DHS help line at **1-800-843-6154** (TTY: **1-800-447-6404**). This line is staffed Monday through Friday, 8:00 a.m. to 5:30 p.m. Central time, except state holidays. If you would like to access the website, you can visit:

www.dhs.state.il.us/page.aspx?item=29439

You can also contact the Long-Term Care Ombudsman Program Illinois Department on Aging at **1-800-252-8966** (TTY: **1-888-206-1327**) or
One Natural Resources Way, Suite 100
Springfield, IL 62702-1271.

You can also call the Senior Health Insurance Program (SHIP) at **1-800-548-9034** (TTY: **1-866-323-5321**).

Medicare Advantage Coverage



Covered Benefits:

- All of the Medicare services
- Urgent Care Emergency Care
- Prescription Drug (Part-D) coverage
 - Medication Therapy Management (MTM) programs for complex health needs

Who do I talk to if I want to?

Access a PCP: Contact your insurance company directly. You can do this by phone or through the plan's website. There will be a member phone number on the back of your Medicare Advantage plan ID card where you can call for help. After you have picked a new PCP, the Medicare Advantage plan should send you a new ID card with the doctor's name on it. As a reminder, your care coordinator is available to help you find a PCP if needed.

Access pharmacy benefits: One of the benefits included in your Medicare Advantage plan is prescription drug coverage. If you have questions on how to access these services, or you have a question about what is covered, call the Member Services number on the back of your Medicare Advantage plan ID card. If you have internet, you can go online to your plan's website for more information. You can also call your care coordinator to help accessing your pharmacy benefits.

File a complaint (grievance) about one or more of your Medicare Advantage covered services: Each Medicare Advantage plan has its own procedure for handling complaints. If you call the number on the back of your Medicare Advantage ID card, someone will be able to help you file your complaint. You can also contact the Long-Term Care Ombudsman Program Illinois Department on Aging or the Senior Health Insurance Program (SHIP) to file a complaint.

You can contact the Long-Term Care Ombudsman Program Illinois Department on Aging at:

1-800-252-8966 (TTY: 1-888-206-1327) or

One Natural Resources Way, Suite 100

Springfield, IL 62702-1271

You can call the Senior Health Insurance Program (SHIP) at **1-800-548-9034 (TTY: 1-866-323-5321)**.

As a member eligible for Medicare and Medicaid, remember Medicare is always the first payer of services.

Medicare Part-D Coverage

	Blue Cross BlueShield of Illinois	Blue Cross MedicareRx (PDP)
Name: Member Name		
ID: 807XXXXXX		
Plan (S0840): 9101000211		
Plan: Blue Cross MedicareRx Basic/Value Plus (PDP)		
Rx Bin: 011552		
Rx PCN: PDPIL/PDGIL		
Rx Grp: 0001/0002/0012/XXXX		
Rx ID: 807XXXXXX		
HPID: TBD CMS S5715 001/002/012/801		

Pharmacy Benefits Covered:

Coverage varies from plan to plan. Depending on what company you get your Part-D coverage through, your benefits will vary.

Some examples of different services are:

- Prescription Drugs covered by Medicare
- Medication Therapy Management for qualifying conditions
- Mail Order Therapy

Who do I talk to if I want to?

Access pharmacy benefits: Talk with your care coordinator, and he or she will be able to help you find what your specific plan covers. If you need help deciding what extra help you have access to, you can call the Center for Medicare and Medicaid Services (CMS). The phone number is **1-800-633-4227**.

You will need a few pieces of information before you call CMS. You will need proof you qualify for Medicaid. To find out what documents you can use, you can call the phone number above. You can also go to www.medicare.gov/your-medicare-costs/help-paying-costs/extra-help/level-of-extra-help.html.

Access your Medicare Part-D covered services: Call the number on the back of your Medicare Part-D card, and ask a representative about what services or prescriptions are covered under your specific plan. Your care coordinator can help understand your Medicare Part-D coverage.

File a complaint (grievance) about one or more of your Medicare Part-D covered services: First contact your care coordinator to let him or her know what is occurring to cause you to be unhappy with your care. Your care coordinator can help walk you through the process of filing a complaint with your Part-D service.

You can also call the Customer Service number located on the back of your Part-D card, and a representative will be able to direct you on the steps needed to file a complaint. You can contact the Long-Term Care Ombudsman Program Illinois Department on Aging at

1-800-252-8966 (TTY: **1-888-206-1327**) or

One Natural Resources Way, Suite 100

Springfield, IL 62702-1271

You can call the Senior Health Insurance Program (SHIP) at **1-800-548-9034** (TTY: **1-866-323-5321**).

File an appeal for your Medicare Part-D covered services: The number on the back of your Part-D card will direct you to the Customer Service line. A representative will be able to direct you on how to file an appeal with your Prescription Drug coverage plan. Every company is different, so you will want to make sure you call your specific Part-D provider.

Your care coordinator is also a very valuable resource; he or she can help you file your appeal. You can also contact the Long-Term Care Ombudsman Program Illinois Department on Aging or the Senior Health Insurance Program (SHIP) to file an appeal.

Care Coordination

Care Coordination provides support to Members with long term services and support needs to ensure that care across providers is coordinated and that services are provided to allow members to live as independently as possible in the community based on where and how they want to live. To understand your needs, we ask that you 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 develop. 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

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

If you want to inquire about care coordination services, please call Member Services.

Transition of Care Services

You are eligible for Transition of Care Services when you are scheduled for a planned inpatient surgical procedure or when you have an unplanned admission to an acute inpatient hospital or skilled nursing facility. Our services help you when you are being discharged home or to a lower level of care. We pay special attention to helping you move from one level of care to another, such as when you are discharged from a hospital or a skilled nursing facility back to your home. It is important that you understand your discharge instructions and have everything you need at home to recover. We work with you to make sure you have

follow-up appointments scheduled. We also make sure you receive all ordered medications and services, including oxygen and durable medical equipment. This ensures a smooth discharge and recovery.

Care Coordinators can help you through the following:

- Arranging services you need, including scheduling and keeping provider appointments
- Ensuring complete communication and coordination of services to provide safe, timely, high-quality care as you move out of an acute inpatient hospitalization stay
- We provide guidance before planned admissions, such as a scheduled surgery. We also provide guidance after discharge when you have had an unplanned admission
- Care coordinators help you understand your conditions to reduce risks of relapse and support your ability to care for yourself.
- We also provide education related to medication safety and the importance of taking medications as the doctor ordered.
- Care coordinators review and clarify your doctor's orders related to care, diet, and activity levels so you understand and can follow the plan of care.

Care Coordination is an opt-out program which means that you don't have to enroll. We will automatically enroll you if you are eligible and we identify an opportunity to help you. To inquire about care coordination, you may call Member Services.

Complex Case Management

We offer a special Complex Case Management program for members that have very complicated illnesses such as kidney disease, depression or substance abuse. If you qualify, you will receive targeted outreach by a care coordinator that specializes in helping members with these complex conditions. You will work with the care coordinator to develop specific goals aimed at improving your overall health.

The care coordinator supports you to:

- Schedule medical appointments as needed
- Arrange transportation to and from medical appointments
- Obtain and understand your medications
- Understand your specific disease and how to improve your health and quality of life
- Help you in using your benefits to keep health issues from getting worse
- Learning tools to help you, your, family and caregivers better understand any health conditions, prescription and over-the-counter drugs, and treatments

The Care Coordinator helps you to use your health benefits and community-based services to reach your health goals.

To inquire about Complex Case Management, call Member Services.

Disease Management

If you have hypertension (high blood pressure), diabetes or asthma, you are eligible for our disease management program. Members identified with hypertension, diabetes or asthma receives support based on the level of their need. All members have access to information and tools to help manage their condition on the web portal called Blue Access for Members. The web portal offers many resources to help you stay healthy. You can access the member web portal at <https://members.hcsc.net/wps/portal/bam>. Members with moderate levels of risk are contacted by a care coordinator that specializes in the management of that condition. If you are enrolled in the program, you work with your care coordinator to develop specific goals with the purpose of improving your overall health.

The care coordinator provides:

- education and materials related to your diagnosis
- assistance with understanding and obtaining medications
- education regarding available benefits that would improve your health outcomes
- referrals to community programs and resources for additional education and support such as improving access to healthy foods and community exercise programs

You may opt out of disease management at any time if you do not wish to participate. To enroll or opt out of the disease management program, you may 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. 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.

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.

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

Illinois WIC Services

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

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

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:

CALL	1-888-775-6875
EMAIL:	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.

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

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/Practitioner Orders for Life-Sustaining Treatment (DNR/POLST) 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.

Grievances & 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 “Adverse Benefit Determination” 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 Adverse Benefit Determination 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 Adverse Benefit Determination 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 Adverse Benefit Determination, 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 Adverse Benefit Decision, 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 Adverse Benefit Decision 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.

Disclaimers

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., 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>.

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)**.

عربي (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): ધ્યાન: જો તમે ગુજરાતી બોલો છો, તો નિ:શુલ્ક સહાયતા સેવાઓ તમને મફત ઉપલબ્ધ છે. ફોન કરો **1-877-860-2837 (TTY/TDD: 711)**.

Urdu (Urdu): ہرکے لیے ہر بھارتیہ نیشنل ایڈجسٹمنٹ سروسز کے ذریعے آپ کو مفت اور بغیر کسی خرچہ کے اردو اور دیگر زبانوں میں گفتگو کرنے کی سہولتیں فراہم کی جاتی ہیں۔ **1-877-860-2837 (TTY/TDD: 711)** پر کال کریں۔

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

λληνικᾶ (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**