Blue Cross Community Health Plans℠

HealthChoice Illinois
Illinois Department of Healthcare and Family Services

Managed Long Term Supports and Services (MLTSS)

Blue Kit℠

Your MLTSS Member Handbook and Certificate of Coverage in one place.

Effective January 2025

IL_BCCHP_MLTSS_WlcmKit25 Approved 10222024 251291.0924

Welcome to Blue℠

Welcome to the Blue Cross Community Health Plans (BCCHP℠) family!

We are glad you are with BCCHP for your Managed Long Term Supports and Services (MLTSS) health plan. MLTSS services help you do things you are no longer able to do for yourself. As part of BCCHP MLTSS you get access to MLTSS providers, behavioral health services and transportation. Care can be given in your home or in a supportive living facility. All with no co-pays for covered MLTSS services.

Use this list to get started using your MLTSS health plan:

- ☐ **Learn what's covered with MLTSS.** This Blue Kit can help. Keep it handy! You can also visit **www.bcchpil.com** to learn about your benefits.
- ☐ **Complete your annual Health Risk Assessment (HRA).** BCCHP will call or text you in the upcoming weeks to complete your HRA. This screening will help your Care Coordinator understand your needs. Call Member Services at **1-877-860-2837** if you missed our call or text.
- ☐ **Log in to your Blue Access for Members℠ (BAM℠) account.** View your health care resources instantly. BAM is the secure member portal for BCCHP members. You can access your account at **www.bcchpil.com** or using the **BCBSIL Mobile App**.
- ☐ **Always keep your MLTSS Member ID card with you.** Use it for all your long-term care services. For medical services, show your Medicare and Medicaid ID Card. For prescription (drug) coverage, use your Medicare Part-D ID Card. See **Health Care Plan Resources on page 21** for further information on other plans.
  - BCCHP will work with your other plans and service providers. That's why it's important to keep your Care Coordinator informed of your medical condition.
- ☐ **To keep your Illinois Medicaid coverage, you will need to renew once a year.** This is called redetermination. You will get a notice from the Department of Healthcare and Family Services (HFS) a month prior to your renewal date. Fill out the forms on time to keep your MLTSS coverage.

If you have questions, please call Member Services toll-free at **1-877-860-2837** (TTY: **711**) or the 24/7 Nurseline at **1-888-343-2697**.

We are here to help!

Member Services

1-877-860-2837

Call to ask about your BCCHP health plan

24/7 Nurseline

1-888-343-2697

Talk to a private nurse about your health 24/7

Frequently Asked Questions (FAQs)

Please refer to the table of contents to find further details on these subjects.

Do I have a co-pay?

No. You will never have a co-pay or deductible for approved MLTSS services.

Do I have medical coverage through my MLTSS plan?

No. BCCHP MLTSS benefits cover your long-term services and supports. For medical coverage, please contact your Medicare, Medicare Advantage, or Medicaid plan. Remember, Medicare is always the first payer of medical services. See **Health Care Plan Resources on page 21** for further information on Medicare and Medicaid plan benefits.

Do I have prescription (drug) coverage through my MLTSS plan?

No. BCCHP MLTSS benefits cover your long-term services and supports.
For prescription coverage, please contact your Medicare Part-D plan. See **Health Care Plan Resources on page 21** to see further information on Medicare Part-D benefits.

What do I do to get emergency care?

Go to the nearest Emergency Room OR Call **911**. Call an ambulance if there is no **911** service in your area. Medical services including ER visits are covered through Medicare, not MLTSS. See page 19 for further information on Medicare and Medicaid plan benefits.

Am I covered by BCCHP outside of Illinois?

BCCHP covers members who live in the state of Illinois. BCCHP does not cover any services outside the United States. A prior authorization will be needed for services outside of Illinois. If a prior authorization is not received, you may have to pay for services. If you need care while you are traveling outside of Illinois, call Member Services at **1-877-860-2837**.

If you need emergency care, go to the closest hospital. Emergency care is covered in the United States. You do not need a prior authorization for emergency services within the US.

How do I learn more about my coverage?

Visit: **www.bcchpil.com**

Blue Access for Members (BAM) Account:

Log in at **https://mybam.bcbsil.com** or with the BCBSIL Mobile App. Download by texting **BCBSILAPP** to **33633**.

Member Services: 1-877-860-2837

A live agent can be reached from 8 a.m. to 5 p.m. CST, Monday - Friday. Self-service or a voicemail can be used 24/7, including weekends and holidays.

Where can I access a list of in-network MLTSS providers?

You can find providers and hospitals near you by using the Provider Finder®. It can be found at **www.bcchpil.com** or on the BCBSIL Mobile App. If you need help finding a doctor, call Member Services at **1-877-860-2837**. You may also access a full list of providers by using the Provider Directory. The Provider Directory can be found at **www.bcchpil.com**.

Can I get a ride to and from my appointments?

Yes. BCCHP uses ModivCare to provide rides to healthcare visits and approved medical trips. To schedule a ride, call ModivCare at least 3 days before. You can also schedule a ride using the new ModivCare app with your smartphone.

How do I access my Member ID Card?

Log in to your BAM account on a desktop or the BCBSIL Mobile App. There you can access a temporary ID Card or order a new one. You can also contact Member Services at **1-877-860-2837**. They can send a new Member ID Card and make sure BCCHP has your current address.

Can I get help from a Care Coordinator?

Yes. A Care Coordinator is a health care "coach" that helps you reach your health goals.

Completing your Health Risk Assessment (HRA) helps us to give you a Care Coordinator. You can ask for a Care Coordinator at any time by calling Member Services at **1-877-860-2837**.

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MLTSS Member Handbook

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If you have questions, please call Member Services toll-free at **1-877-860-2837** (TTY: **711**) or the 24/7 Nurseline at **1-888-343-2697**.

Important Phone Numbers

24/7 Nurseline 24-hour-a-day help line — **1-888-343-2697**, TTY/TDD: **711**

Member Services — **1-877-860-2837**, TTY/TDD: **711**

We are available 24 hours a day, seven days a week. The call is free.

A live agent can be reached from 8 a.m. to 5 p.m. Central time, Monday through Friday.

Self-service or a voicemail can be used 24/7, including weekends and holidays.

Website — **www.bcchpil.com**

Service Area — The plan covers members who live in the state of Illinois.

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**
Behavioral Health Crisis Line	**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**
Supportive Living Facilities Complaint Hotline	**1-844-528-8444**

Emergency Care — **911**

In an emergency, call **911** or go the nearest emergency department.
Emergency care is covered in all of the United States.

Member Services

Welcome to Blue Cross Community Health Plans. Member Services is ready to help you get the most from BCCHP. Member Services is available at **1-877-860-2837** (TTY/TDD: **711**). We are available 24 hours a day, seven (7) days a week. The call is free. A live agent can be reached from 8 a.m. to 5 p.m. Central Time, Monday through Friday. Self-service or a voicemail can be used 24/7, including weekends and holidays. 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

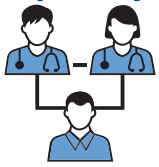
Blue Access for Members℠ (BAM)℠

Access Your HealthCare 24/7 From Wherever You May Be

It's easier than ever to stay connected using your secure portal. With BAM, you can manage your health coverage and find info about your services. And now, you can access your personal BAM account with your smartphone. Just use the BCBSIL mobile app!

If you haven't already signed up for BAM, you can access online or through our mobile app:

https://mybam.bcbsil.com



Log in on your desktop or tablet via our website. Located on the upper righthand corner!

BCBSIL Mobile App

Download the mobile app. Use your phone's app store by searching BCBSIL or text* **BCBSILAPP** to **33633**

Just some of what BAM offers:

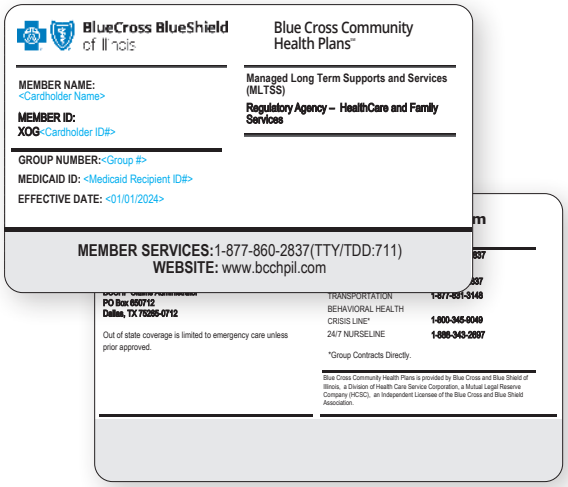
- Request, print or order an ID card
- Find doctors, specialists and hospitals using the Provider Finder℠
- Change your Primary Care Provider (PCP)
- View your prior authorization and claims information

*Message and data rates may apply.

If you have questions, please call Member Services toll-free at **1-877-860-2837** (TTY: **711**) or the 24/7 Nurseline at **1-888-343-2697**.

Member Identification (ID) Card

You will receive a MLTSS Member ID Card. You should always carry your card with you. It has important phone numbers. You will need to show it when you get waiver or long-term services. Use your Medicare ID Cards for other services, such as prescriptions and medical services. Call Member Services at **1-877-860-2837** if you don't have a Member ID Card.



Information on your Member ID Card:

- Name
- Plan Name
- State Medicaid ID #
- Member ID #
- Enrollment Effective Date
- Group #
- Benefit Group #
- Member Services #
- BCCHP Website
- Transportation #
- Behavioral Health Crisis Line #
- 24/7 Nurse Hot Line #
- Where providers are to send claims
- Name & Address of MCO
- State Regulator

Eligibility

You are eligible for MLTSS coverage under Blue Cross Community Health Plans if the following applies to you:

- You are eligible for Medicare Part A and Medicare Part B
- You are eligible for Medicaid
- You are age 21 and older at the time of enrollment
- You are enrolled in the Medicaid Aid to the Aged, Blind and Disabled category of assistance
- You do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated

You meet all other criteria and need services from one of the following Medicaid 1915(c) waivers:

- Persons who are Elderly
- Persons with Disabilities
- Persons with HIV/AIDS
- Persons with Brain Injury
- Persons who are in the Supportive Living Program

Illinois state agencies will continue determine your eligibility for some programs. This includes your home and community-based services or residence at a nursing facility. BCCHP works with agencies to assist with your long-term services and supports.

Renewal of Medicaid Benefits (Redetermination)

Don't Risk Losing Your Medicaid Benefits – Complete Your Rede Ontime!

Each year you complete a renewal process to keep your benefits. Renewal is sometimes called redetermination or Rede. Rede is a review of your eligibility for Medicaid, SNAP or cash assistance. The state must decide whether you still meet the rules to keep getting benefits. You need to renew your Medicaid coverage at least once every year. If you receive SNAP benefits you will do this twice a year.

Here's How:

1. Click *Manage My Case* at abe.illinois.gov

- Create or log in to your account at **abe.illinois.gov** to manage your benefits. Online is the best way to connect

2. Verify your address

- If you use Medicaid, you need to keep your address current. Click Manage My Case and verify your address under Contact Us or call Member Services at **1-877-860-2837** (TTY/TDD: **711**)

3. Find your due date (also called a redetermination date)

- To find your due date, check your Benefit Details tab at **abe.illinois.gov**

4. Watch your mail

- The Department of Healthcare and Family Services (HFS) will mail you a notice a month before your due date. It will tell you if you need to complete a renewal form. The notice gives steps on how to complete your redetermination

5. Complete your redetermination

- Don't risk losing your Medicaid. You have multiple ways you can submit your renewal

  Submit your Medicaid redetermination by:

  - **Submitting online.** Click *Manage My Case* at **abe.illinois.gov**
  - **Mailing or faxing** your completed form and any requested verifications
  - **Over the phone** by calling **1-800-843-6154**
  - **In-person.** To find a location, use the IDHS Office Locator at **www.dhs.state.il.us**

Beware of scams. Illinois will never ask you for money to renew or apply for Medicaid. Report scams to **https://hfs.illinois.gov/oig/reportfraud.html** or the Medicaid fraud hotline at **1-844-453-7283**/**1-844-ILFRAUD**.

If you have questions, please call Member Services toll-free at **1-877-860-2837** (TTY: **711**) or the 24/7 Nurseline at **1-888-343-2697**.

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 MLTSS 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 new MLTSS members, there is a 90-day transition period. For members who switch to BCCHP from another plan, there is also a 90-day transition period. If necessary, your Care Coordinator will help transition services to an in-network provider.

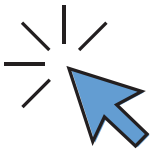
Provider Network

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 BCCHP to provide you LTSS.

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. Except in an emergency, the plan does not cover out-of-network services. Ask the provider if they are in the BCCHP network before you get care.

How to find a provider, including your PCP:

Provider Finder℠



www.bcchpil.com
Search 24/7 online or use the BCBSIL Mobile App

Provider Directories

www.bcchpil.com
View or download a PDF of providers

Member Services

1-877-860-2837
The call is free

Telehealth

BCCHP has made it easier to see your provider by offering Telehealth options. You can get the care you need, even virtually. To learn more, call Member Services at **1-877-860-2837** or ask your doctor if they provide telehealth. Each doctor, if offered, has different ways of providing telehealth services. If you need help making an appointment, please contact Members Services.

Primary Care Provider (PCP)

Your PCP 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.

Your PCP is covered through your Medicaid or Medicare benefits. Blue Cross Community Health Plans MLTSS covers your long-term services and supports. For medical coverage, contact your Medicare, Medicare Advantage or Medicaid Plan.

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

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, he or she will work with you to choose a specialist. Your PCP will arrange your specialty care.

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.

Blue Cross Community Health Plans MLTSS covers your long-term support services. For care given by a PCP or specialist, contact your Medicare, Medicare Advantage or Medicaid plan.

Urgent Care

Urgent care is an issue that needs care right away but is not life threatening. For urgent care, contact your Medicare or Medicare Advantage Plan.

Examples of urgent care:

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

Call your doctor for urgent care or you can call MLTSS Member Services at **1-877-860-2837**.
You can always call the **24/7 Nurseline** at **1-888-343-2697**.

Emergency Care

An emergency medical condition is very serious. It could even be life threatening. You could have severe pain, injury, or illness. In an emergency, call **911** or go the nearest Emergency Department. For emergency care coverage, please contact your Medicare or Medicare Advantage Plan.

Some examples of an emergency are:

- Stroke symptoms (sudden weakness, blurred vision, slurred speech)
- Heart attack
- Severe bleeding
- Poisoning
- Difficulty in breathing
- Broken bones

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. You should call us within 24 hours of emergency care

Prior Authorization

Some services may require a prior authorization or getting an OK from BCCHP. You do not need to contact us for prior authorization. You can work with your doctor to submit a prior authorization.

For HCBS members, your Care Coordinator will work with you and take care of prior authorization. Without a prior authorization for these services, BCCHP will not pay for these services.

The MLTSS plan does not cover medical services. Instead, your Medicare or Medicaid plan covers medical services. You may need to get a prior authorization for some medical services. Contact Medicare or Medicaid to learn what medical services need a prior authorization.

Managed Long Term Supports and Services (MLTSS) Covered Services

BCCHP will provide or arrange for covered, medically necessary, health care services to a member in accordance with the provisions of the Certificate of Coverage. Descriptions of health care services are also available in the Certificate of Coverage. You may have to pay for care not listed or if you do not get prior authorization.

BCCHP does not cover services outside the United States. If you need care while you are traveling outside of Illinois, call Member Services at **1-877-860-2837**. A prior authorization is needed for services outside of Illinois. If a prior authorization is not received, you may have to pay for services. If you need emergency care, go to the closest hospital. Emergency care is covered in all the United States. You do not need a prior authorization for emergency services within the US. Call Member Services at **1-877-860-2837** if you have questions about what BCCHP covers.

Here is a list of some of the services and benefits that BCCHP covers:

Nursing Care Services

These services focus on members' long-term needs rather than short-term acute care. Members with Disabilities, HIV/AIDS, or Traumatic Brain Injury (TBI) Waivers are eligible.

Based on a State evaluation, a 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), registered in 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. For example, Nursing Home, Long-Term Care Facility, or Skilled Nursing Facility. A Nursing Facility is a licensed facility that gives skilled nursing (short period of time) or long-term care services (long-term stays where you are living in the facility). **These services need a prior authorization (OK) from BCCHP.**

Physical Therapy, Occupational Therapy and Speech Pathology

Members with Disabilities, HIV/AIDS and TBI Waivers may qualify. This requires a physician order.

Behavioral Health Services (BH)

BH services can help those facing mental health conditions. The type of service you might need depends on your personal situation. Some services may require prior authorization. You do not need a referral for a provider that is in our network.

If you are experiencing a behavioral health crisis, call the **Behavioral Health Crisis Line** at **1-800-345-9049**. This is a 24-hour crisis intervention and stabilization service.

Some of the BH services covered include:

- Community-based alcohol or drug treatments
- Community-based behavioral health services
- BCCHP may cover substance abuse treatments.

Substance abuse treatments we cover include:

- Outpatient services
- Medication assisted treatment
- Residential treatment detoxification

Pathways to Success

Members under the age of 21 who have significant behavioral health needs may qualify. This includes children with Serious Emotional Disturbance or Serious Mental Illness. The Pathways Program gives additional home and community-based services.

Services may include family peer support, intensive home-based care, therapeutic mentoring, respite, therapeutic and individual support services. To learn more about this program and how to qualify call Member Services at **1-877-860-2837**.

Covered Home and Community Based Services (waiver clients only)

Here is a list of some of the medical services and benefits that BCCHP covers for members who are in a Home and Community Based Service Waiver. These services may require prior authorization.

Department on Aging (DoA)

Persons Who Are Elderly

- Adult Day Service
- Adult Day Service transportation
- Homemaker
- Personal Emergency Response System (PERS)
- Automated medication dispenser

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
- 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 Program

- 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
  - Provided without a required referral or prior authorization
  - Used for exercise
  - More than one piece of equipment that does the same thing
  - For hygiene or looks
- Care 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 are still 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)

BCCHP does not cover cannabis. Cannabis comes from the cannabis plant. It has delta-9-tetrahydrocannabinol (THC) as an active ingredient. Cannabis may be called marijuana. BCCHP does not cover cannabis in any form. This includes:

- Plant seeds
- Extracted resin
- Salt or other derivative
- Any mixture or preparation of cannabis-derived compounds

Note: This is not a full list of services not covered.

For more information on services, review your Certificate of Coverage or call Member Services at **1-877-860-2837** (TTY/TDD: **711**).

New Medical Treatments

BCCHP reviews new medical treatments. A group of PCPs, specialists and medical directors decides if a treatment:

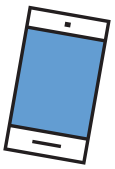
- Has been approved by the government
- Has shown how it affects patients in a reliable study
- Will help patients and improve their health as much as, or more than, current treatments

The review group looks at this and decides if the treatment is medically necessary. If your doctor asks about a new treatment not yet reviewed, our medical group will review and decide. They will let your doctor know if it is medically necessary and approved.

Non-Emergency Transportation Services

BCCHP is working with ModivCare to provide transport services. You can get a ride to a provider appointment, pharmacy (following your appointment) or a BCCHP event. You can also get a ride to a Blue Door Neighborhood Center.

To Schedule a Ride



ModivCare App

Search 'ModivCare' in your app store and use for all your ride needs

Call ModivCare

1-877-831-3148

Monday – Friday 8 a.m. – 6 p.m., CST

Confirm Your Ride

1-877-831-3148

Call or check your mobile app 3 days prior

The day of your appointment

- Be ready for your ride one hour beforehand
- When your driver comes, they will honk, knock, ring the bell, or call you. They must wait 5 minutes for you. After 5 minutes, they can leave and report a no-show
- Drivers can transport multiple members on the same ride. This should not add any more than 45 minutes to your travel time

Return Ride

- You may pre-schedule a return ride. The driver should come within 30 minutes
- If you do not have a pre-scheduled pick-up time, call ModivCare when you are done with your visit. The driver should come within an hour of the call

A parent or caregiver may ride with children or members with special needs. Anyone that is not the member must be approved when the ride is scheduled. You are responsible for any medical equipment or safety seat. This includes wheelchairs or car seats for a child. BCCHP does not cover rides for non-medical reasons, except to BCCHP sponsored events.

Without special approval, BCCHP does not cover rides:

1. more than 65 miles away
2. to out-of-network providers

You do not need authorization for emergency transport.

If a driver is running late, call the Where's My Ride Line at 1-877-831-3149. If needed, ModivCare will work to make other arrangements. A grievance can be made against ModivCare by calling Member Services or ModivCare. You can request to not have a specific transportation provider for future rides.

ModivCare App

The ModivCare app gives you the flexibility to schedule your medical ride whenever and wherever you like. All you need to do is search 'ModivCare' on either Google Play® or the Apple App Store® to download. Make sure to have an email address handy to create your account. Then requesting a ride is only a few clicks away!

By downloading the ModivCare app you have access to:

- Booking, changing, or cancelling rides
- Live ride tracking
- Driver's real-time location and ETA
- Text or calling the driver to ensure trips aren't missed

Other Transportation

If you live within two blocks of a mass transit bus stop, you can get free bus passes. Bus passes can be provided to get you to and from your doctor's appointment. Call ModivCare at least two weeks before your appointment to request bus passes. Bus passes will be mailed to your home.

Value-Added Benefits

Members have access to additional benefits. Below are examples of those extras just for you.

Blue365®

Members get a free membership to Blue365. It is a program that offers exclusive health and wellness discounts. Visit our website at **www.blue365deals.com** to learn more.

Over-the-Counter Drugs and Supplies

Over-the-counter (OTC) drugs and supplies are medicines and items you buy at the pharmacy without a prescription. As a BCCHP member, you can order $25 in approved OTC items one time quarterly (every three months) at no cost to you. Benefit amounts will not roll over to the next quarter. You can view the OTC Catalog at **www.bcchpil.com**. You can place an order online at **www.mpaotc.com**. First time users will need to register an account. You can also place an order by calling Member Services at **1-877-860-2837**. Your order will be shipped at no cost to your address within 7 to 10 days.

Cell Phone

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

Transportation

You may get transportation to a provider appointment, pharmacy (following your appointment), or to BCCHP-sponsored events. This is in addition to the standard transportation benefit. Learn more on **page 19** or at **www.bcchpil.com**.

Smoking Cessation

A care coordinator can connect you with resources to help you to stop smoking.

Health Care Plan Resources

In addition to BCCHP, you may have to work with other health plans. This includes Medicare, Medicare Advantage, and/or Medicare Part-D (Prescription Drug) Plans. Below is general information on other healthcare plans and how to access your benefits. Please contact your health plan provider for a full list of benefits and coverage.

Health Care Plans

- **Medicare:** With this coverage, you can go to any doctor who takes Medicare patients. Medicare Part A may cover hospital care, skilled nursing care or home health services. Medicare Part B may cover services such as doctor's visits, preventative care, or emergency care. You can call **1-800-633-4227** (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
- **Medicare Part-D:** Coverage varies from plan to plan depending on what company you get your Part-D coverage. Some benefits you may receive from Medicare Part-D include prescription drugs, medication therapy and mail order therapy. You can go to the Medicare website at **www.medicare.gov/part-d** to see what drugs are covered under different Part-D plans
- **Medicare Advantage:** Your Medicare Advantage may cover all services provided under Medicare, including urgent care and emergency care, plus prescription (Part D) coverage. Contact your insurance company directly for more information. There will be a member phone number on the back of your Medicare Advantage plan ID card where you can call for help
- **Medicaid:** As a member eligible for Medicare and Medicaid, remember Medicare is always the first payer of services. Some services your Medicaid plan may cover include nursing facility services, physician services, vision, and dental services. Please see the BCCHP Member Handbook for a full list of services and benefits covered

Filing a Compliant (Grievance)

First, contact your Care Coordinator to let them know what is occurring. Your Care Coordinator can help walk you through the process of filing a complaint. You can also call the customer service number on the back of your ID card.

- **Medicare Service Complaint:** 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. You can also contact the Illinois Department on Aging Long-Term Care Ombudsman Program
- **Medicaid Service Complaint:** Call the DHS help line at **1-800-843-6154** (TTY: **1-866-324-5553**). 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**
- **Medicare Advantage and Medicare Part-D Service Complaint:** Each Medicare Advantage and Medicare Part-D 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 Illinois Department on Aging Long-Term Care Ombudsman Program or the Senior Health Insurance Program (SHIP) to file a complaint

Helpful Phone Numbers

- Department on Aging: **1-800-252-8966** (TTY: **1-888-206-1327**)
- Illinois Department on Aging Long-Term Care Ombudsman Program: **1-800-252-8966** (TTY: **1-888-206-1327**)
- Senior Health Insurance Program (SHIP): **1-800-252-8966** (TRS: **711**)

Care Coordination

Care Coordination provides support to members with long term services and support needs. Care Coordination helps ensure care across providers and services. It is to allow members to live as independently as possible. To understand your needs, please complete a Health Risk Assessment (HRA) annually. The HRA helps us determine how your Care Coordinator may assist you. They will be your health care "coach". They will oversee your 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 will help you get the care you need to be healthy. And they will assist in managing your health condition.

This includes:

- Developing a service plan when you have home and community-based services
- Tips on how to help manage your weight, eat better, and stay fit with an exercise program
- Provide brochures with tips on how to manage a chronic condition or on-going condition
- Access to Recovery Support Assistants to support you in your recovery journey from mental health or addiction
- Give well care tips about healthy behaviors and the need for routine exams and screenings
- 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 at **1-877-860-2837**.

Transition of Care Services

You are eligible for Transition of Care Services. They cover:

1. planned inpatient surgical procedures
2. unplanned admissions to an acute inpatient hospital or nursing care facility

These 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.

For example, 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 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. This ensures a smooth discharge and recovery.

Care Coordinators can help you by:

- 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 the hospital.
- Understanding your conditions and supporting your ability to care for yourself
- Providing guidance before planned admissions, such as a scheduled surgery.
- Providing guidance after discharge when you have had an unplanned admission
- Providing education related to your medication and doctor's orders
- Reviewing and clarifying your doctor's orders related to care, diet and activity levels so you can understand and follow the plan of care

Care Coordination is an opt-out program. This 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 at **1-877-860-2837**.

Complex Case Management

We offer a special Complex Case Management program for members with complicated illnesses. For example, kidney disease, depression, or substance abuse. If you qualify, you will get targeted outreach by a Care Coordinator to help with your condition. You will work with your Care Coordinator to develop specific goals. These goals will help improve your overall health.

Your Care Coordinator supports you by:

- Scheduling medical appointments as needed
- Arranging transportation to and from medical appointments
- Obtaining and understanding your medications
- Helping you understand your specific disease and how to improve your health and quality of life
- Helping you use your benefits to keep health issues from getting worse
- Offering learning tools to help you, your family and caregivers better understand any health conditions, prescriptions, over-the-counter drugs, and treatments

Disease Management Program

If you have hypertension (high blood pressure), diabetes or asthma, you are eligible for this program. Members identified get support based on their level of need. All members have access to Blue Access for Members (BAM) for tools and help. The web portal offers many resources to help you stay healthy. You can access the member web portal at **https://mybam.bcbsil.com**. Members with moderate risk are contacted by a Care Coordinator that specializes in that condition management. If you are enrolled in the program, you work with your Care Coordinator to develop specific goals. These goals will help improve 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 more education and support such as improving access to healthy foods and community exercise programs

Complex Case and Disease Management Referrals

You can be referred to the Complex Case Management or Disease Management Program by a:

- self-referral
- caregiver or provider
- discharge planner
- medical management team

Voluntary Service

A Care Coordinator helps you use your health benefits and community-based services. This is so you can reach your health goals. Care coordination and care coordination programs are voluntary (except for waiver services). You can opt-out at any time. If you are eligible, we will automatically enroll if we identify an opportunity to help you. To enroll in or opt-out of Care Coordination, call Member Services at **1-877-860-2837**.

Health Education Programs

BCCHP has programs to help you stay healthy and manage illnesses at every stage of life.

Regular visits to your PCP to get recommended immunizations helps you stay healthy. Any needed immunizations and screenings will be provided during the visit. Please review the below table with you PCP.

Adult Recommended Preventative Services	
If You Are	**You Need**
Age 19-20	Annual Physical Exam, Annual Flu Shot, Tetanus-Diphtheria Booster (every 10 years). Additional Immunizations as recommended by your PCP
Age 21-34	Annual Physical Exam, Annual Flu Shot, Tetanus-Diphtheria Booster (every 10 years), Pap Smear, Chlamydia Screening, HPV Vaccine (< age 26)
Age 35-49	Annual Physical Exam, Annual Flu Shot, Tetanus-Diphtheria Booster (every 10 years), Pap Smear, Cholesterol Testing (> age 44), Glaucoma Screening (> age 39), Baseline Mammogram (covered once for members age 35-40), Annual Screening Mammogram (> age 40)
Age 50-64	Annual Physical Exam, Annual Flu Shot, COVID-19 vaccination, Shingles vaccine, Tetanus-Diphtheria Booster (every 10 years), Pap Smear, Mammogram, Cholesterol Testing, Colorectal Cancer Screening, Glaucoma Screening
Age 65+	Annual Physical Exam, Annual Flu Shot, Tetanus-Diphtheria Booster (10 years), Pneumococcal Vaccine, Mammogram (to age 74), Cholesterol Testing, Colorectal Cancer Screening (to age 75), Glaucoma Screening, Hearing Screening

Call Member Services at **1-877-860-2837** to learn more about these programs. You can also check out our website. Look under Member Resources at **www.bcchpil.com**. These programs are designed to help you be well and stay well.

Blue Door Neighborhood Centers®

Blue Door Neighborhood Centers are community hubs. They give a space to learn, connect and focus on your health. They offer education, health and wellness programs, and access to community resources. BDNCs offer free services that are available to all, not just members.

Mission: Working hand in hand with the community to provide access to whole-person health and wellness resources.

Vision: To be a trusted partner and resource for community members along their health journeys. The Blue Door Neighborhood Center provides the following: condition management, health education & promotion, and social determinants of health (SDOH) programming.

Learn more about BDNCs and upcoming events at **www.bcbsil.com/bdnc**.

Visit a BDNC at:

Morgan Park Center	Pullman Center	South Lawndale Center
1-872-760-8090	**1-773-253-0900**	**1-872-760-8450**
11840 S. Marshfield Ave. Chicago, IL 60643	756 E. 111th St. Suites 102 & 103 Chicago, IL 60628	2551 W. Cermak Road Chicago, IL 60608

Blue365®

Blue365 allows members to save money on care products not usually covered by BCCHP. Members and dependents have access to a range of discounts. This includes top retailers on fitness gear, gym passes, healthy eating and more. There are no claims to file, no referrals, and no added fees to participate. To begin, visit **www.blue365deals.com**.

Learn to Live: Behavioral Health Platform

Learn to Live is a no cost online health program. It is offered to members 13 and older and caregivers. Learn to Live gives self-paced mental health solutions. Plus, access to 24/7 member coaches. It can help with common challenges like stress, anxiety, depression, insomnia, and substance abuse. To start, register at **www.Learntolive.com/Welcome/BCBSILMedicaid**. (Access Code: **ILMED**).

For Your Peace of Mind

Our 24/7 Nurseline lets you talk in private with a nurse about your health. Call toll-free, 24 hours a day, seven 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/AID

BCCHP also offers Transition of Care Services, Complex Case Management, and Disease Management Services. Please see **Care Coordination on page 22** for details.

In addition to BCCHP programs, there are also other state resources available to you. Please call Member Services at **1-877-860-2837** for further information.

The Ombudsman Program

Illinois Long Term Care Ombudsman Program

The Illinois Long-Term Care Ombudsman Program (LTCOP) is a program offered by the Illinois Department on Aging. It 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.

Please use the following information to learn more:

Email: aging.ilsenior@illinois.gov

Website: https://ilaging.illinois.gov/programs/ltcombudsman.html

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

Illinois Home Care Ombudsman Program

The Illinois Home Care Ombudsman Program provides advocacy and assistance to older persons and persons with disabilities. Specifically, members that live in the community and get services through HCBS Waiver Programs. A Home Care Ombudsman can help you understand MCO or HCBS Waiver Program services. They can help connect you to your BCCHP or HCBS Waiver Program Care Coordinator.

Please use the following information to learn about the Illinois Home Care Ombudsman Program:

Email: aging.HCOProgram@illinois.gov

Website: https://ilaging.illinois.gov/programs/ltcombudsman/the-home-care-ombudsman-program.html

Phone Number: 1-800-252-8966; TTY: **1-888-206-1327**

Advance Directives

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

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

You can get more information on advance directives from BCCHP 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

We want you to be happy with services you get from MLTSS and our providers. If you are not happy, you can file a grievance or appeal.

Grievances

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

MLTSS 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. MLTSS 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.

If the grievant is a customer of the Vocational Rehabilitation (VR) program, the grievant may have the right to the assistance of the DHS-ORS Client Assistance Program (CAP) in the preparation, presentation and representation of the matters to be heard.

These are examples of when you might want to file a grievance. Your provider or a BCCHP staff member did not respect your rights.

- Your provider or a BCCHP 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 BCCHP staff member was rude to you
- Your provider or a BCCHP 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 660717
Dallas, Texas 75266

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 at **1-877-860-2837**.

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 Member Services TTY/TDD line **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 BCCHP 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 an "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 BCCHP 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 letter. 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 letter.

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 660717
Dallas, Texas 75266

Standard Fax: **1-866-643-7069**
Expedited Fax: **1-800-338-2227**

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 Member Services TTY/TDD line 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.

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 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.

BCCHP will send our decision in writing to you **within fifteen (15) business days** of the date we received your appeal request. BCCHP may request an extension up to f**ourteen (14) more calendar days** to decide on your case if we need to get more information before we decide. 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 BCCHP's 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 BCCHP's decision does not agree with the Adverse Benefit Determination, 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 BCCHP reviews your appeal.

How can you expedite your Appeal?

If you or your provider believes our standard timeframe of **fifteen (15) business days** to decide 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 Determination letter, information about your case and why you are asking for the expedited appeal. You may also fax an expedited appeal to BCCHP, please fax expedited appeals to **1-800-338-2227**. 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. You may do this in writing or verbally. You may withdraw your appeal using the same address as used for filing your appeal or by calling Blue Cross Community Health Plans at **1-877-860-2837** (TTY/TDD: **711**). Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request. If you need further information about withdrawing your appeal, call Blue Cross Community Health Plans at **1-877-860-2837** (TTY/TDD: **711**).

BCCHP 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 Member Services at **1-877-860-2837** (TTY/TDD: **711**).

What happens next?

After you receive the BCCHP 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 act 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 BCCHP 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 **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: **1-312-793-2005**
Email: **HFS.FairHearings@illinois.gov**

Or you may call **1-855-418-4421**, TTY: **1-800-526-5812**

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: **1-312-793-8573**
Email: **DHS.HSPAppeals@illinois.gov**

Or you may call **1-800-435-0774**, TTY: **1-877-734-7429**

State Fair Hearing Process

The hearing will be conducted by an Impartial Hearing Officer authorized to conduct State Fair Hearings. You will receive a letter from the appropriate Hearings office informing you of the date, time, and place of the hearing. This letter will also provide information about the hearing. It is important that you read this letter carefully. If you set up an account at **https://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 BCCHP. 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 BCCHP 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 BCCHP Appeal Decision Notice, you may choose to ask for a review by someone outside of BCCHP. 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.
PO Box 660717
Dallas, Texas 75266

Standard Fax: **1-866-643-7069**
Expedited Fax: **1-800-338-2227**

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.
PO Box 660717
Dallas, Texas 75266

Expedited Fax: **1-800-338-2227**

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

Rights & Responsibilities

Your Rights:

- A right to always be treated with respect and dignity in recognition of your privacy
- Have your personal health information and medical records kept private except where allowed by law, and when necessary to provide care
- Be protected from discrimination
- Receive information from Blue Cross Community Health Plans in other languages or formats such as with an interpreter or Braille
- Receive information on available treatment options and alternatives
- Receive information necessary to be involved in making decisions about your healthcare treatment and choices
- A right to make recommendations regarding the organization's member rights and responsibilities policy
- 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 Blue Cross Community Health Plans. You can change your PCP at any time
- File a complaint (sometimes called a grievance), or appeal without fear of mistreatment or backlash of any kind
- Request and receive in a reasonable amount of time, information about your Health Plan, its providers and polices including member rights and responsibilities.

Your Responsibilities:

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

Fraud, Abuse and Neglect

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

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

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

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

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

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

If you believe you are a victim, you should report this right away. You can call Member Services at **1-877-860-2837**.

If You Suspect Abuse, Report It

By law, it is your responsibility to report allegations of abuse and neglect. You should call 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 person is enrolled in the Supportive Living Program Waiver and suspected abuse, neglect or exploitation please call the SLP Hotline at **1-844-528-8444**.
- 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 the DOA Adult Protective Services 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 BCCHP Member Services at **1-877-860-2837** (TTY/TDD **711**). You can also use our Fraud and Abuse hotline at **1-800-543-0867**. We are available 24/7.

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

Definitions:

Appeal means a request for BCCHP 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 BCCHP.

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.

Social Determinants of Health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

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.

Privacy Policy

We have the right to get information from your caregivers. 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. If you would like a copy of the notice, please call Member Services at **1-877-860-2837** (TTY/TDD: **711**).

Blue Cross Community Health Plans is working with the State of Illinois to stop new HIV cases. The Illinois Department of Public Health is sharing HIV data they have with IL Medicaid and IL Medicaid Managed Care Organizations to have better care for people living with HIV. Name, date of birth, SSN, HIV status and other information is being shared safely and securely for all Medicaid members.

Disclaimers

ModivCare is an independent company that has contracted with Blue Cross and Blue Shield of Illinois to provide transportation services for members with coverage through BCBSIL.

BCBSIL makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

Learn to Live, Inc. is an independent company offering online tools and programs for behavioral health support. Learn to Live is an educational program and should not be considered medical treatment.

MLTSS Certificate of Coverage

If you have questions, please call Member Services toll-free at **1-877-860-2837** (TTY: **711**) or the 24/7 Nurseline at **1-888-343-2697**.

Blue Cross Community Health Plans is provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association.

Blue Cross Community Health Plans, otherwise known as BCCHP, has contracted with the Illinois Department of Healthcare and Family Services (HFS) to give health care coverage.

This Certificate is issued by Blue Cross and Blue Shield of Illinois (BCBSIL), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association, operating as a health maintenance organization.

In consideration of the Member's enrollment, BCBSIL shall arrange for covered health care services to the Member in accordance with the provisions of this Certificate of Coverage.

This Certificate of Coverage may be subject to amendment, modification or termination by agreement between Blue Cross Community Health Plans and the Illinois Department of Healthcare and Family Services 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 BCBSIL coverage, members agree to all terms and conditions. The effective date of coverage under this Plan is stated on your Member ID card that was mailed to you.

Description of Coverage Worksheet

BCCHP covers members who live in the state of Illinois. BCCHP does not cover services outside the United States. If you need care while you are traveling outside of Illinois, please call the customer service number on your Medicare or Medicare Advantage Plan, Medicaid and your Prescription Drug (Medicare Part-D) Plan ID card. BCCHP does not cover services outside of the United States.

Managed Long Term Supports and Services (MLTSS) Covered Services

You will never have a co-pay or deductible for BCCHP covered services. Some services may require a prior authorization from BCCHP, as shown in the charts below. Call Member Services at **1-877-860-2837** (TTY/TDD: **711**) with any questions.

COVERED SERVICES		
MLTSS Medical Services	**Blue Cross Community MLTSS Health Plans Benefit Limit/Exclusions**	**Provider Must Obtain Prior Authorization**
Behavioral Health Services	Including, but not limited to: • Community-based behavioral health • Crisis Services • Outpatient services, such as a medication management, therapy, and counseling • Day treatment at a hospital	Yes, under certain circumstances
Environmental Home Adaptations	These services are covered as part of the written plan of care.	Yes

COVERED SERVICES		
MLTSS Medical Services	**Blue Cross Community MLTSS Health Plans Benefit Limit/Exclusions**	**Provider Must Obtain Prior Authorization**
Nursing Care Services	A written order from a physician may be required before getting nursing care services.	Yes
Nursing Facility Services	A written order from a physician may be required before getting nursing care services.	Yes
Transportation (non-emergency)	Call Member Services for a ride at least 72 hours before the appointment. You are responsible for any medical equipment such as a wheelchair. Transport for non-medical reasons is not covered. Prior authorization is needed for rides that are more than 65 miles away. Also needed for providers not in network.	Yes, under certain circumstances

Covered Home and Community-Based Services (HCBS) - Waiver Members Only

Below is a list of some of the medical services and benefits that BCCHP covers for members who are in a HCBS Waiver

HCBS Waiver Program	Services	Provider Must Obtain Prior Authorization
Department on Aging (DoA) Persons who are Elderly	• Adult Day Service • Adult Day Service transportation • Homemaker • Personal emergency response system (PERS)	Yes
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 • Physical therapy • Speech therapy • Homemaker • Home delivered meals • Personal assistant • Personal emergency response system (PERS) • Respite	Yes

If you have questions, please call Member Services toll-free at **1-877-860-2837** (TTY: **711**) or the 24/7 Nurseline at **1-888-343-2697**.

HCBS Waiver Program	Services	Provider Must Obtain Prior Authorization
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.)	Yes
HealthCare and Family Services (HFS) **Supportive Living Program**	• Assisted Living	You may need a prior authorization from us before you get covered services.

In addition to these covered services, BCCHP offers value-added benefits. See **page 20** for more details.

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 BCCHP
- 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)

BCCHP does not cover cannabis. Cannabis comes from the cannabis plant. It has delta-9-tetrahydrocannabinol (THC) as an active ingredient. Cannabis may be called marijuana. BCCHP does not cover cannabis in any form. This includes:

- Plant seeds
- Extracted resin
- Salt or other derivative
- Any mixture or preparation of cannabis-derived compounds

Note: This is not a full list of services that are not covered.

For more information on services, please review your Member Handbook or contact Member Services at **1-877-860-2837**.

Prior Authorization

Some services may require a prior authorization from BCCHP. 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
- Find out what is wrong or treat the disease, illness, or injury
- Help you do things like eating, dressing, and bathing

You do not need to contact us for prior authorization. Your doctor will take care of this for you and if you receive home and community-based services, your care coordinator will take care of this for you Getting a prior authorization takes between 2-8 calendar days. To check service limits, see the section called "Covered Medical Services". Your PCP can also tell you about this.

We will not pay for services from a provider that is not part of the BCCHP network. You must get a prior authorization from us before getting the services.

Continuity of Treatment

Continuity of Treatment is to make sure you can continuously be treated after enrolling. New members have a 90-day transfer period. This period allows you time to switch from any out-of-network providers. This is also to give you time to transfer any services. During this time, providers you see must be registered to give Medicaid services. Your Care Coordinator will work with you to transfer your care and services.

Urgent Care

Urgent care is an issue that needs care right away but is not life threatening. Blue Cross Community Health Plans MLTSS covers your long-term services and supports. For urgent care, contact your Medicare, Medicare Advantage, Medicaid, or Medicare Part-D Plan.

Some examples of urgent care are:

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

Call your doctor for urgent care or you can call Member Services at **1-877-860-2837**. You can also call the 24/7 Nurseline at **1-888-343-2697**.

Emergency Care

An emergency medical condition is very serious. It could even be life threatening. You could have severe pain, injury or illness. In an emergency, call **911** or go the nearest emergency department. MLTSS covers your long-term services and supports. For emergency care coverage, contact your Medicare, Medicare Advantage or Medicaid Plan.

Some examples of an emergency are:

- Stroke symptoms (sudden weakness, blurred vision, slurred speech)
- Heart attack
- Severe bleeding
- Poisoning
- Difficulty in breathing
- Broken bones

Other Resources

To find further information about your plan, please see the **Table of Contents on page 6**. Information on Grievances and Appeals, Rights and Responsibilities, Fraud, Abuse and Neglect, the Privacy Policy, and the Non-Discrimination Statement can be found in the MLTSS Member Handbook Section of this Kit.

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. You can file a grievance by phone, mail, or fax. 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 https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.

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)**.

POLSKI (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **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).**

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

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)**.

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-860-2837** (رقم **هاتف الصم والبكم: 711).**

РУССКИЙ (Russian): ВНИМАНИЕ: Если Вы говорите на русском языке, то Вам доступны бесплатные услуги перевода. Звоните **1-877-860-2837 (Телетайп: 711)**.

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

اردو (Urdu):
یاد رکھیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔
1-877-860-2837 (TTY: 711) پر کال کریں۔

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)**.

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)**.

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

FRENCH (French): ATTENTION: Si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le **1-877-860-2837 (TTY/TDD : 711)**.

ΕΛΛΗΝΙΚΑ (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **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)**.

Managed Long Term Supports and Services (MLTSS)

Blue Kit℠

Your MLTSS Member Handbook and Certificate of Coverage in one place.