Blue Cross Community Health Plans℠

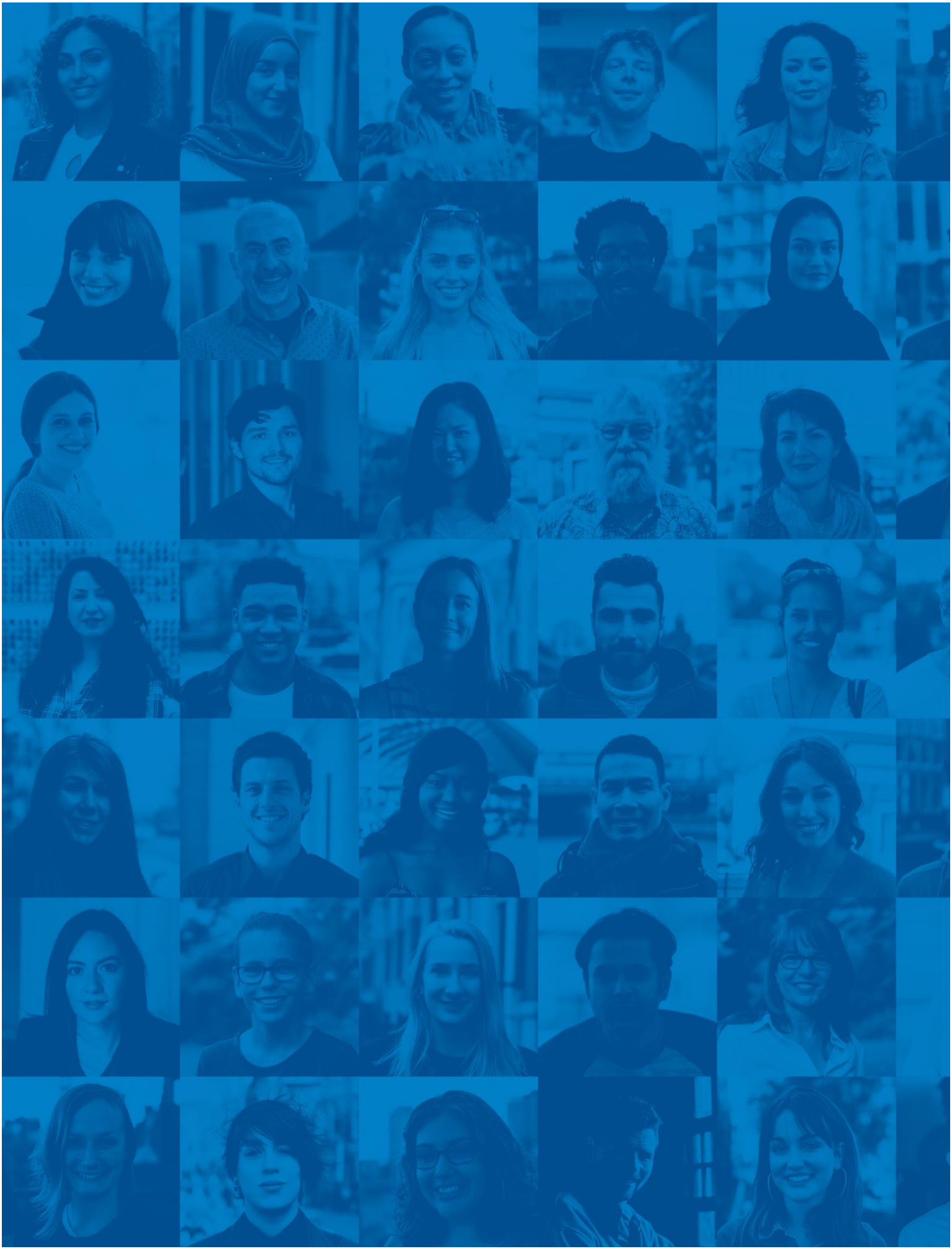
Department of Healthcare & Family Services
HealthChoice Illinois
Your Health. Your Choice.

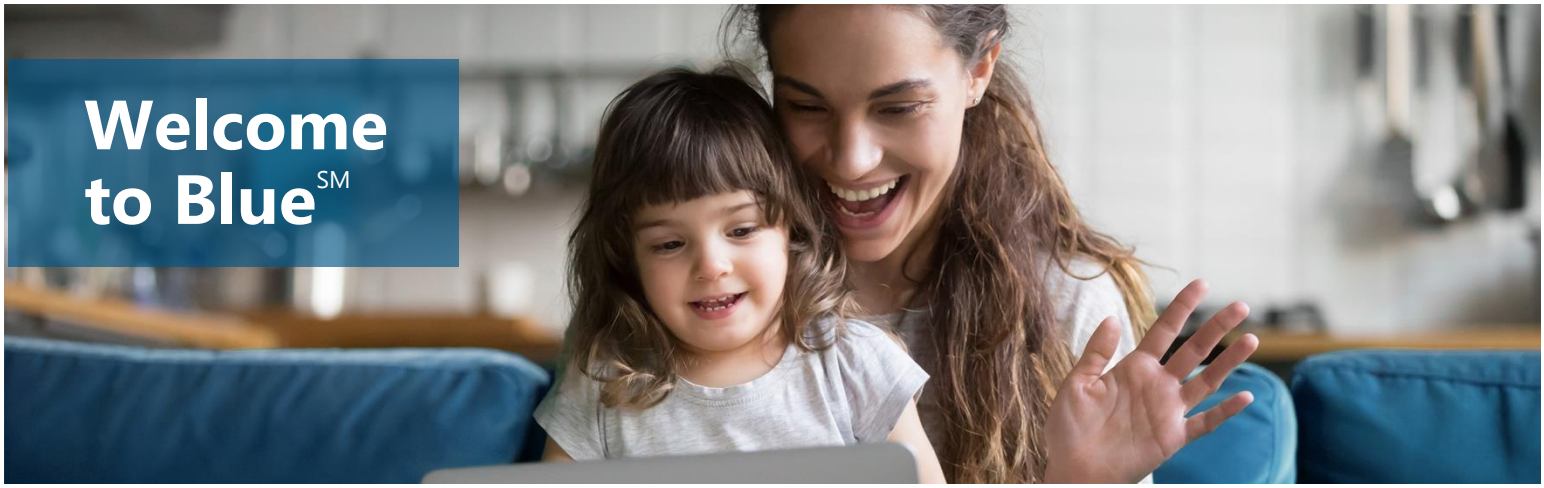
Welcome to Blue℠

Blue Kit℠

Your Member Handbook and Certificate of Coverage in one place.

Effective: June 2020





Welcome to the **Blue Cross Community Health Plans℠ (BCCHP)** family! We are glad you are with BCCHP for your Medicaid health plan. You now have access to 7,000 primary care doctors, 26,000 specialists and 170 hospitals. You will never have a co-pay! We are here to answer any questions about your plan. You can call Member Services 24 hours a day, seven (7) days a week at **1-877-860-2837** (TTY/TDD **711**). The call is free.

This is your Blue Kit. It contains important information about your benefits. Below is a quick list to get you started using this booklet and your BCCHP benefits.

1. Please take a few minutes to check out what's inside this Blue Kit. We want you to get the most out of your medical coverage.
   - ❑ **Learn what's covered with BCCHP**. The Member Handbook and Certificate of Coverage can help you to get started using your benefits. Keep them handy! You can also visit **www.bcchpil.com** to learn about your benefits.
2. You should have already received your Blue Cross Community Health Plans (BCCHP) **Member ID Card(s)** in the mail. If you did not, call Member Services. Keep your ID card with you at all times and show it every time you need healthcare services.
   - ❑ **Find your primary care provider (PCP)** on your ID card. If you want to switch your PCP call Member Services. If you switch your PCP we will send you a new ID Card.
3. Complete your annual Health Risk Screening (HRS).
   - ❑ **BCCHP will call or text you** in the upcoming weeks to complete your HRS. This screening will help determine your health habits, if you have any health risks and if you need a Care Coordinator. Call Member Services if you missed our call or text and would like to complete your HRS.
4. Set up an initial health exam with your PCP.
   - ❑ **Call to schedule an appointment** with your PCP within 30 days of joining the Plan. During the first exam, the PCP will learn about your health care needs. This is to help you stay healthy. Call Member Services if you need a ride to and from your appointment.
5. Log in to your free Blue Access for Members (BAM℠) account. BAM is the secure member portal for BCCHP members. You can log in at **www.bcbsil.com**.
   - ❑ **View all of your health care resources instantly** from home using BAM. Some tools you can use with BAM include finding network providers and hospitals and review your claims status. Plus, you can order or print a replacement ID card.

Keep your Medicaid coverage

Be aware of your HealthChoice Illinois (Medicaid) renewal, or redetermination date. To keep your Medicaid coverage, you will need to renew once a year. You will receive forms from Healthcare and Family Services (HFS) a few months prior to your renewal date. Fill out the forms on time to keep your medical coverage.

Frequently Asked Questions (FAQs)

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

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 area). You don't need a prior authorization for emergency services. BCCHP pays for emergency services in the U.S.

Who do I call when I need care?

Start by calling your PCP's office. You can always call the **24-hour Nurse Help Line at 1-888-343-2697.** Member Services is also available to answer any questions you may have about your care.

Do I have a co-pay?

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

Do I have dental and/or vision services?

Yes! With BCCHP, you get dental and vision coverage. See the Dental and Vision Sections to learn more.

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

You can find providers and hospitals near you by using the **Provider Finder®** which can be found at **www.bcbsil.com.** You may also access a full list of providers by using the Provider Directory. The Provider Directory can be found at **www.bcchpil.com** on the Forms and Documents page. You can ask for a printed copy of the Provider Directory to be mailed to you for free by calling Member Services.

You can change your PCP at any time by calling Member Services or using your BAM account. You can log in to BAM at **www.bcbsil.com.** It's best to keep the same PCP. This is so they can get to know your health needs.

I have an appointment scheduled but have not received my Member ID Card. What are my options?

Please contact Member Services to send a new Member ID Card and make sure BCCHP has your current address. You may also log in to your BAM account to access a temporary Member ID Card or order a new one.

How do I know what medications are covered under the plan?

To find out if a drug is covered, visit our website at **www.bcchpil.com** or call Member Services. BCCHP uses a Preferred Drug List (PDL). This is to help you and your doctor choose which drugs to give you. You can ask for a printed copy of the Preferred Drug List (PDL) to be mailed to you for free by calling Member Services.

Can I get a ride to and from my appointments?

BCCHP uses LogistiCare to provide rides to healthcare visits and approved medical trips. To schedule a ride, call Member Services at least 72 hours (3 days) before your appointment.

Can I get help from a Care Coordinator?

Yes. A Care Coordinator is a health care "coach" that can help you reach your health goals. Completing your Health Risk Screening (HRS) helps us decide if you will need a Care Coordinator. You can ask for a Care Coordinator at any time as part of BCCHP.

Table of Contents

Member Handbook

Certificate of Coverage

Blue Cross Community Health Plans℠

Department of Healthcare & Family Services
HealthChoice Illinois
Your Health. Your Choice.

Member Handbook

WWW.BCCHPIL.COM

1-877-860-2837 /
711 (TTY/TDD)

Important Phone Numbers

24/7 Nurseline 24-hour-a-day help line	**1-888-343-2697,** TTY/TDD: **711**
Emergency Care*	**911**
Blue Cross Community Health Plans Member Services We are available 24 hours a day, seven (7) days a week. The call is free. **Website**: **www.bcchpil.com**	**1-877-860-2837,** TTY/TDD: **711**
Non-Emergency Medical Transportation	**1-877-831-3148,** TTY/TDD: **1-866-288-3133**
Behavioral Health Services	**1-877-860-2837,** TTY/TDD: **711**
Mobile Crisis Response	**1-800-345-9049,** TTY/TDD**: 711**
Grievances and Appeals	**1-877-860-2837,** TTY/TDD: **711**
Fraud and Abuse	**1-800-543-0867,** TTY/TDD: **711**
Care Coordination	**1-855-334-4780,** TTY/TDD: **711**
Adult Protective Services	**1-866-800-1409** TTY: **1-888-206-1327**
Nursing Home Hotline	**1-800-252-4343,** TTY**: 1-800-547-0466**
DentaQuest	**1-877-860-2837,** TTY/TDD: **711**
Davis Vision	**1-877-860-2837,** TTY/TDD: **711**
Illinois Department of Public Health	**1-217-782-4977**

** In an emergency, call 9-1-1 or go the nearest Emergency Department. Emergency care is covered in all of the United States.*

Member Services

You can call Blue Cross Community Health Plans Member Services at **1-877-860-2837** (TTY/TDD: **711**). We are available 24 hours a day, seven (7) days a week. The call is free. Our staff is trained to help you understand everything about your health plan. We can give you details about your medical, dental and vision benefits. We can also answer questions you may have about:

- Needing help in other languages
- Getting your medications/prescriptions
- What are covered/non-covered services
- Choosing/Changing your Primary Care Provider (PCP)
- Needing a ride to a doctor's appointment or pharmacy
- Renewing your Medicaid benefits
- Filing a grievance or an appeal
- Your rights and responsibilities

Telephone Access

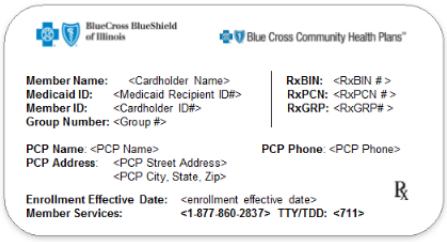
You can reach your PCP (primary care doctor) 24-hours a day at the PCP phone number on your Member ID card. After regular business hours, an answering service or recording will instruct you on how to receive care after hours. If you have a medical question or problem and cannot reach your PCP you can call the BCCHP 24/7 Nurseline at **1-888-343-2697** (TTY/TDD: **711**). If you have an emergency, call 911 or go to the nearest Emergency Room (ER).

Member Identification (ID) Card

We sent you a Blue Cross Community Health Plans Member ID Card when you enrolled. You should always carry your card with you. It has important phone numbers. You will need to show it when you get services. Call Member Services at **1-877-860-2837** (TTY/TDD: **711**) if you have not received your Member ID Card, lose your card or if you need to change your PCP. We will automatically send you a new card if your PCP's address or phone number changes.

Information on your Member ID Card

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



Eligibility

Medicaid Eligibility

You can join Illinois Medicaid if **ONE** of the following describes you. You then qualify for Blue Cross Community Health Plans medical coverage.

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

To begin online enrollment, visit the Illinois Client Enrollment services website at **https://enrollhfs.illinois.gov/enroll.** On this site, you can choose a health plan and pick a primary care provider (PCP). Illinois Client Enrollment Services will send you information about your health plan choices when it is time for you to select a health plan.

Open Enrollment

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 BCCHP please contact the Client Enrollment Service (CES) at **1-877-912-8880**.

Redetermination

Renewal of Medicaid Benefits (Redetermination)

Renewal is sometimes called redetermination or REDE. You need to renew your Medicaid coverage at least once every year (if you receive SNAP benefits you will do it twice a year). If you have questions about your Medicaid renewal, visit the Illinois Department of Human Services Automated Benefits Eligibility (ABE) website at abe.illinois.gov or the Customer Call Center at **1-800-843-6154**.

Provider Network

Blue Cross Community Health Plans partners with doctors, specialists and hospitals to provide medical services to you. You should use 'in-network' providers. If you choose to see a doctor who is not part of our network, you will have to pay for the services. Except in an emergency, the plan does not cover out-of-network services. Ask the provider if they are in the BCCHP network before you get care.

You may need to get approval for some services before you are treated. This is called "prior-authorization." BCCHP may not cover a service if you don't get approval. You may have to pay if you get care outside your service area if it is not an emergency and you do not have prior authorization.

If you need help finding a doctor, call Member Services at **1-877-860-2837 (**TTY/TDD: **711)**. You can also find in-network providers and hospitals near you by using the **Provider Finder®** which can be found at **www.bcbsil.com.** You may also access a full list of providers by using the Provider Directory. The Provider Directory can be found at **www.bcchpil.com** on the Forms and Documents page. You can ask for a printed copy of the Provider Directory to be mailed to you for free by calling Member Services.

Other Providers

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

Primary Care Provider (PCP)

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

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

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

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

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

How to Change PCPs

You can change your PCP anytime on the Blue Access for Members (BAM) portal or by calling Member Services. To log in to your BAM account visit **www.bcbsil.com.** Member Services can be reached at **1-877-860-2837** (TTY/TDD: **711**). We are available 24 hours a day, seven (7) days a week. The call is free. Unless a change is truly needed, it's best to keep the same PCP. This is so your provider can get to know your health needs and history. If you do change your PCP, be sure to have your medical records sent to the new provider.

Women's Health Care Provider (WHCP)

As a woman with Blue Cross Community Health Plans coverage, you have the right to select a Women's Health Care Provider (WHCP). A WHCP is a doctor licensed to practice medicine specializing in obstetrics, gynecology or family medicine. You do not need a prior authorization to see a WHCP that is in-network.

Family Planning

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

Covered family planning services include:

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

Some services are not covered:

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

Specialty Care

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

Scheduling Appointments

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

When going to your doctor's appointment:

- Take your Member ID card
- Be on time for your appointment
- Call the doctor's office right away if you are going to be late or need to cancel

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

Urgent Care

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

Some examples of urgent care are:

- Minor cuts and scrapes
- Colds
- Fever
- Earache

Call your PCP for urgent care or call Member Services at **1-877-860-2837** (TTY/TDD: **711**). We are available 24 hours a day, seven (7) days a week. The call is free.

Emergency Care

An emergency medical condition is very serious. It could even be life threatening. You could have severe pain, injury or illness. In an emergency, call 9-1-1 or go the nearest Emergency Department. Emergency care is covered in all of the United States. Prior authorization is not needed, but you should call your PCP and Member Services within 24 hours of your emergency care so they can make sure you get all the follow-up care you need.

Some examples of an emergency are:

- 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, but you should call us with 24 hours of your emergency care

Post-Stabilization Care

Post-Stabilization Services are needed services that are given to you following an emergency medical condition. These services are given to make sure you feel better and stay better. Some Post-Stabilization Services after an emergency are covered by BCCHP. An example of a covered service would be a follow up office visit for counseling. Please call Member Services at **1-877-860-2837** (TTY/TDD: **711**) to see if your Post-Stabilization Service is eligible or if a prior authorization is needed.

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. Your doctor will take care of this for you.

Both BCCHP and your PCP (or specialist) will agree which services are medically necessary. "Medically necessary" refers to services that:

- Protect life
- Keep you from getting seriously ill or disabled
- Finding out what's wrong or treating the disease, illness or injury
- Help you do things like eating, dressing and bathing

We won't pay for services from a provider or doctor that isn't part of the BCCHP network if you didn't get an authorization from us before getting the services.

Some services that do not need a prior authorization are:

- Primary care
- In-network specialist
- Family planning
- WHCP services (you must choose doctors in the network)
- Emergency care

Coverage Decisions

BCCHP has strict rules about how decisions are made about your care. Our doctors and staff make decisions about your care based only on need and benefits. There are no rewards to deny or promote care. BCCHP does not encourage doctors to give less care than you need. Doctors are not paid to deny care.

You can talk to a BCCHP staff member about our utilization management (UM) process. UM means we look at medical records, claims, and prior authorization requests. This is to make sure services are medically necessary. We also check that services are provided in the right setting and that services are consistent with the condition reported. If you want to know more about this process or how decisions are made about your care, contact Member Services at **1-877-860-2837** (TTY/TDD: **711**).

Getting a Second Medical Opinion

You may have questions about care your PCP or doctor says you need.

You may want a second opinion to:

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

You should speak to your PCP if you want a second opinion.

They will send you to a doctor who:

- Also works with BCCHP
- Is the same kind of doctor you saw for the first opinion

You will need a prior authorization from BCCHP to see a doctor who isn't in our network.

Call Member Services at **1-877-860-2837** (TTY/TDD: **711**) for help getting a second opinion. You can also call the 24/7 Nurseline at **1-888-343-2697** (TTY/TDD: **711**) to learn more.

Covered Services

BCCHP will pay for all services under the Covered Medical Services section of this Member Handbook.

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

Your PCP may send you to a specialist or other provider for medical tests. They may make the appointment for you. A referral is not required. Sometimes you will have to make the appointment yourself. This is called a self-referral. You may also call Member Services at **1-877-860-2837** (TTY/TDD: **711**) for help with appointments.

BCCHP will provide and/or arrange for covered health care services to you in accordance with the provisions of the Certificate of Coverage. A description of covered health care services is also available in the Blue Cross Community Health Plans Certificate of Coverage, which is included as part of your Welcome Kit.

Call Member Services if you have questions about what BCCHP covers.

Covered Medical Services

Blue Cross Community Health Plans wants to ensure you get the care you need. BCCHP pays for all medically necessary Medicaid covered services. You do not have any co-pays. If you have health-related questions you can call our 24/7 NurseLine at **1-888-343-2697** (TTY/TDD: **711**).

Some services may require a prior authorization or have service limits. Your doctor will submit any necessary prior authorizations. For additional coverage details see the BCCHP Certificate of Coverage.

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

- Abortion services are covered by Medicaid (not your MCO) by using your HFS Medical card
- Advanced practice nurse services
- Ambulatory Surgical Treatment Center services
- Assistive/Augmentative communication devices
- Audiology (hearing) services
- Blood, blood components and the administration thereof
- Chiropractic services for members under age twenty-one (21)
- Dental services, including oral surgeons
- EPSDT services for members under age Twenty-one (21)
- Family planning services and supplies
- Federally-Qualified Health Center (FQHC), Rural Health Clinic (RHC), and other Encounter rate clinic visits
- Home health agency visits
- Hospital Emergency Department visits
- Hospital inpatient services
- Hospital ambulatory services
- Laboratory and x-ray services
- Medical supplies, equipment, prostheses and orthoses
- Mental health services
- Nursing care
- Nursing facility services
- Optical services and supplies
- Optometrist services
- Palliative and hospice services
- Pharmacy services
- Physical, occupational and speech therapy services
- Physician services
- Podiatric services
- Post-Stabilization services
- Renal dialysis services
- Respiratory equipment and supplies
- Services to prevent illness and promote health
- Subacute alcoholism and substance abuse services
- Transplants
- Transportation to secure covered services

Covered Home and Community Based Services (Waiver members 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.

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 Facility:*

- Assisted living

Managed Long Term Support & Services (MLTSS) Covered Services

If you receive Managed Long Term Support & Services, a separate handbook is available. It contains information about supplemental benefits that apply only to MLTSS members. If you need a copy of this handbook, please call Member Services at **1-877-860-2837** (TTY/TDD: **711**).

MLTSS Covered Services include:

- Mental health services like: group and individual therapy, counseling, community treatment, medication monitoring and more
- Alcohol and substance use services like: group and individual therapy, counseling, rehabilitation, methadone services, medication monitoring and more
- Some transportation services to appointments
- Long term care services in skilled and intermediate facilities
- All home and community-based waiver services like the ones listed above under 'Covered Home and Community Based Services' if you qualify

Limited Covered Services

- BCCHP may provide sterilization services only as allowed by state and federal law
- If BCCHP provides a hysterectomy, BCCHP shall complete HFS Form 1977 and file the completed form in the Enrollee's medical record

Non-Covered Services

Here is a list of some of the medical services and benefits that BCCHP does not cover:

- Services that are experimental or investigational in nature
- Services that are provided by a non-network provider and not authorized by BCCHP
- Services that are provided without a required referral or prior authorization
- Elective cosmetic surgery
- Infertility care, such as sterilization reversals and fertility treatments, such as artificial insemination or in-vitro fertilization
- Any service that is not medically necessary
- Services provided through local education agencies
- Weight loss drugs or diet aids
- Cosmetic dentistry
- Tooth bleaching and whitening
- Dental Implants
- Contact lens insurance
- Low vision aids
- Laser eye vision correction

This is not a full list of services not covered.

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

Dental Services

BCCHP has partnered with DentaQuest to provide dental services. Dental providers take care of your teeth. You do not need a prior authorization from your PCP for dental care. Visit our website at **www.bcchpil.com** to find an in-network dental provider or call Member Services at **1-877-860-2837,** TTY/TDD: **711**.

For members over the age of 21, BCCHP covers the following dental services*:

- Two (2) oral exams per year
- Two (2) teeth cleanings per year
- One (1) set of preventive x-rays per year
- Emergency dental Services
- Fillings
- Crowns
- Limited root canals
- Limited dentures
- Limited oral surgery
- Extractions

For members under the age of 21, BCCHP covers the following dental services*:

- One (1) fluoride treatment per year
- Sealants
- Fillings
- Crowns
- Root canals
- Dentures
- Extractions
- Emergency dental services

Eligible pregnant members can get these additional dental services prior to the birth of their baby*:

- Periodic oral examination
- Teeth cleaning
- Periodontal work

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

**Some limits may apply to these services.*

Vision Services

BCCHP has partnered with Davis Vision to provide vision services. Vision providers take care of your eyes. You do not need a prior authorization from your PCP for vision care. Visit **www.bcchpil.com** to find a vision provider or call Member Services at **1-877-860-2837,** TTY/TDD: **711**.

Services include:

- One (1) eye exam every 12 months per member
- Eye Glasses:
  - + Covered every two years for members 21 and older
  - + Replaced “as needed” for members under 21
  - + You can get $40 toward a pair of upgraded eyeglass frames every two years
- Contact lenses are covered when medically necessary, if glasses cannot provide the intended result

If glasses or contacts are lost or stolen, contact Member Services at **1-877-860-2837,** TTY/TDD: **711**. You can always call Member Services if you have any questions about what is and is not covered. We will pay only for those services we authorize.

Pharmacy Services

BCCHP uses a Preferred Drug List (PDL). The PDL is provided by the Illinois Department of Healthcare and Family Services (HFS). BCCHP must follow the HFS provided PDL. This is to help your doctor choose which drugs to give you. Certain drugs on this list need a prior authorization ahead of time or have limits based on medical necessity. Your doctor will choose which drug is best for you. The PDL can be found at **www.bcchpil.com** on the Forms and Documents page. You can also call Member Services to learn what drugs are on the PDL. To get a free printed copy of the PDL mailed to you, please call Member Services at **1-877-860-2837** (TTY/TDD: **711**).

You will need to get your medication at a network pharmacy. You will receive up to a 30-day supply. You do not have copays on covered prescriptions filled at in-network pharmacies. We want to protect your health and keep you safe. Make sure your doctor and pharmacist know what medicines you are taking. This includes over-the-counter drugs.

Over-The-Counter (OTC) Drugs 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 $40 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 on our website at **www.bcchpil.com** on the Forms and Documents page. To place an order call Member Services at **1-877-860-2837** (TTY/TDD: **711**). Your order will be shipped to your address within 7 to 10 days.

Network Pharmacies

There are many pharmacies in our network. To find one in your area, use the **Provider Finder®** which can be found at **www.bcbsil.com** or call Member Services. You may also access a full list of pharmacies by using the Pharmacy Directory. The Pharmacy Directory can be found at **www.bcchpil.com** on the Forms and Documents page. You can ask for a printed copy of the Pharmacy Directory to be mailed to you for free by calling Member Services. Make sure to take your Member ID card and your prescription/medicine order from your doctor when you visit the pharmacy. If you need help getting to your pharmacy call Member Services. There is also information on non-emergency transportation in the next section.

Mail-Order Program

We offer a mail-order program for chronic disease medicines. You can get up to a 90-day supply sent directly to your home. There is no cost to you. Call Member Services at **1-877-860-2837** (TTY/TDD: **711**) for more information.

Drugs not on the PDL

Call Member Services to find out if your drug is on the PDL. The PDL can also be found at **www.bcchpil.com** on the Forms and Documents page.

If it is not on the PDL, you have two options:

- Talk to your provider to decide if you can first try a drug on the PDL before you ask for an exception.
- Call Member Services to ask for an exception to cover your drug. Send a statement from your doctor backing your request. BCCHP must decide within 24 hours (one day) of getting your doctor's request.
- Exception requests are usually only approved if other drugs on the PDL would make your treatment(s) less effective or would be harmful to your health.

Transportation Services

Non-Emergency Transportation Services

BCCHP has partnered with LogistiCare to provide transport services. You can get a ride to a provider's appointment, pharmacy or a BCCHP sponsored event. BCCHP does not cover rides for non-medical reasons, except to BCCHP sponsored events. Without special approval, BCCHP does not cover rides that are more than 40 miles away or to providers not in network.

Call **1-877-860-2837** (TTY/TDD: **711**) to schedule a ride **at least three (3) days in advance**. Call **911** for emergency transport only. You do not need an authorization from BCCHP for emergency transport.

A parent or caregiver may ride with children or members with special needs. If you are a member who is a single caregiver, and you have more than one minor child in your care, you can ask Member Services to approve transportation for additional minor children. Caregivers or other children must be approved to ride by BCCHP when the ride is scheduled.

LogistiCare can be reached at **1-877-831-3148** (TTY/TDD: **1-866-288-3133)**. LogistiCare is available Monday through Friday, 8:00 a.m. to 6:00 p.m., CST.

The day of your appointment

- You should be ready for your ride one hour before your visit. You are responsible for any medical equipment or safety seat. This includes wheelchairs or car seats for a child.
- When your driver comes, they will honk, knock, ring the bell, or call you. They must wait 5 minutes for you to come to the vehicle. After 5 minutes, they may leave your location and report this as 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.
- If your driver does not show up call Member Services at **1-877-860-2837** (TTY/TDD: **711**). To file a complaint, see the Grievance and Appeals section of this handbook.

After your visit

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

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 LogisitiCare at least two weeks before your appointment to request bus passes. Bus passes will be mailed to your home.

Call LogistiCare at least 72 hours (3 days) before your appointment to confirm your trip. They will give you a trip reservation number. You can call LogistiCare at **1-877-831-3148** (TTY: **1-866-288-3133**) Monday through Friday, 8:00 a.m. to 6:00 p.m., CST.

Added Benefits

BCCHP 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.bcbsil.com** to learn more.

Over-the-Counter (OTC) Drugs and Supplies

OTC drugs and supplies are medicines and items you buy at the pharmacy without a prescription. As a BCCHP member, you can order $40 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**. To place an order call Member Services at **1-877-860-2837** (TTY/TDD: **711**). Your order will be shipped to your address within 7 to 10 days.

Dental Services

In addition to covered dental benefits, members with developmental disabilities or serious mental illness can go for practice visits to the dentist.

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 pharmacy, provider appointment or to BCCHP-sponsored events. This is in addition to the standard transportation benefit. Additional information for the standard transportation benefit can be found on Page 20 or **www.bcchpil.com.**

Vision Services

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

Smoking Cessation

You can get help to stop smoking.

Special Beginnings Program®

Pregnant members who join Special Beginnings will receive education and support to guide them through pregnancy and delivery.

You may qualify for:

- Free car seat or free portable crib for going to a prenatal appointment in your first trimester
- Two (2) free packages of diapers after 6-week post-partum doctor's visit
- $30 gift card for going to at least six (6) well child appointments from birth to 15 months

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

Healthy Incentives Program

You may qualify for gift cards for completing certain preventive services as part of the Healthy Incentives Program such as:

- $15 gift card for women age 50-74 who get an annual breast cancer screening
- Members with diabetes can get a $15 gift card for having a yearly retinal exam with a doctor

Blue Access for Members (BAM℠)

Blue Access for Members (BAM) is the secure member portal for BCCHP. You can view all of your health care resources instantly from home.

Some resources you can access when logging into your BAM account, include:

- Ordering a new ID card or print a temporary ID card
- Finding doctors, health care providers, pharmacies and hospitals
- Completing a health risk screening
- Getting the most up-to-date information about your Care Coordinator
- Finding out what services and medications are covered by your plan
- Getting access to a variety of health and wellness topics
- Viewing prior authorization information
- Finding a new doctor who is taking new patients with **Provider Finder®**

You can explore all of these features and tools by registering for BAM at **www.bcbsil.com**. For any questions or help logging in, call Member Services at **1-877-860-2837** (TTY/TDD: **711**).

Cost Sharing

BCCHP does not charge co-pays or deductibles for covered medical services or prescriptions. This means you should not receive any bills for covered or prior authorized services.

Care Coordination

Members will complete a Health Risk Screening (HRS) at least annually. BCCHP will call or text you after enrolling to complete your HRS. This screening will help determine your health habits, if you have any health risks and if you need a Care Coordinator. Call Member Services if you missed our call or text and would like to complete your HRS.

The HRS helps us determine if you will need a Care Coordinator. If you qualify for Care Coordination and choose to stay in Care Coordination, a Care Coordinator will be assigned to you. This Care Coordinator will work with us to assist you in managing your care. They will be your health care “coach”. They will oversee the plan of care you and your Care Team decide is right. Care Coordinators can help you reach your health goals using your benefits.

Your BCCHP Care Coordinator will:

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

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

- Tips on how to help manage your weight, eat better and stay fit with an exercise program
- 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

Transition of Care Services

You are eligible for Transition of Care Services when you are scheduled for a planned inpatient surgical procedure or when you have an unplanned admission to an acute inpatient hospital or skilled nursing facility. Our services help you when you are being discharged home or to a lower level of care. We pay special attention to helping you move from one level of care to another, such as when you are discharged from a hospital or a skilled nursing facility back to your home. It is important that you understand your discharge instructions and have everything you need at home to recover. We work with you to make sure you have follow-up appointments scheduled. We also make sure you receive all ordered medications and services. 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 coordination of services to provide safe, timely, high-quality care as you move out of the hospital
- Providing guidance before planned admissions, such as a scheduled surgery. Also, providing guidance after discharge when you have had an unplanned admission
- Understanding your conditions to reduce risks of relapse and support your ability to care for yourself
- Providing education related to your medication and doctor's orders

Complex Case Management

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

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

The Care Coordinator provides:

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

Voluntary Service

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

Care Coordination and Care Coordination programs are voluntary (except for waiver services) and you can opt-out at any time. We will automatically enroll you if you are eligible and we identify an opportunity to help you.

To enroll in or opt-out of any Care Coordination services or programs, call Member Services at **1-877-860-2837** (TTY/TDD: **711**).

Health Education Programs

Blue Cross Community Health Plans has programs to help you stay healthy and to manage illness at every stage of life.

For children, regular visits to their pediatrician or PCP allows your child to get recommended immunizations to keep them healthy. The doctor checks your child for normal growth and development. This helps prevent health problems later. The doctor can check diet and physical activity, healthy weight, dental, vision and behavioral health.

The table below shows how often your child should see their doctor for exams. Any needed immunizations and screenings will be provided during the visit.

Age Range	Recommended Visit Frequency
1 – 6 months	Every 2 months
6 – 18 months	Every 3 months
18 months – 3 years	Every 6 months
3 – 19 years	Every year

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

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, 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

You can use the programs below and get information about them at no cost. Call Member Services to learn more about these programs. You can also check out our website. Look under Member Resources at **www.bcchpil.com**. These programs are designed to help you be well and to stay well.

Blue365®

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

Special Beginnings®

Special Beginnings helps pregnant moms better understand and manage their pregnancies and to deliver a healthy baby without complications. If you are pregnant or have delivered a baby within the last 84 days (as a BCCHP member), you are eligible for the program.

Program participants may be eligible to receive:

- Education on pregnancy, postpartum, and newborn care
- Program incentives just for going to prenatal visits and postpartum appointments
- Help finding a provider and assistance with issues with access to care
- A breast pump and extra benefits (Dental, Vision, Transportation)

You may opt out of Special Beginnings at any time. To enroll or opt out of the Special Beginnings program, call Member Services.

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 (7) days a week at **1-888-343-2697** (TTY/TDD: **711**). A nurse can give you details about health issues and community health services.

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

- Allergies and immune system
- Children's health
- Diabetes
- High blood pressure
- Sexually transmitted diseases such as HIV/AIDS

BCCHP also offers Transition of Care Services, Complex Case Management, and Disease Management Services. Please see the Care Coordination section on Pages 22-24 for details.

In addition to the programs Blue Cross Community Health Plans offers, there are also many other local and state resources available to you and your family. Please call Member Services at **1-877-860-2837** (TTY/TDD: **711**) if you would like further information.

The 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. For more information on the LTCOP visit the IL. Department on Aging website at **Illinois Department on Aging, Long-Term Care Ombudsman Program**.

Recipient Restriction Program

BCCHP monitors prescription drug use as part of the Recipient Restriction Program.

We look for warning signs such as:

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

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

Advance Directives

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

- **Healthcare Power of Attorney** - This lets you pick someone to make your health care decisions if you are too sick to decide for yourself.
- **Living Will** - This tells your doctor and other providers what type of care you want if you are terminally ill which means you will not get better.
- **Mental health Preference** - This lets you decide if you want to receive some types of mental health treatments that might be able to help you.

- **Do Not Resuscitate/Practitioner Orders for Life-Sustaining Treatment (DNR/POLST) order** - This tells your family and all your doctors and other providers what you want to do in case your heart or breathing stops.

You can get more information on advance directives from 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 BCCHP 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.

BCCHP 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. BCCHP 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.
- 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 27838
Albuquerque, NM 87125-9705
Fax: **1-866-643-7069**

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

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file your grievance. If you are hearing impaired, call the 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 27838
Albuquerque, NM 87125-9705
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 **fourteen (14) more calendar days** to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension, if you need more time to obtain additional documents to support your appeal.

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

If 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 make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Adverse Benefit 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 take action by asking for a State Fair Hearing Appeal and/or asking for an External Review of your appeal within **thirty (30) calendar days** of the date on the Decision Notice. You can choose to ask for both a State Fair Hearing Appeal and an External Review or you may choose to ask for only one of them.

State Fair Hearing

If you choose, you may ask for a State Fair Hearing Appeal within **one hundred-twenty (120) calendar days** of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within **ten (10) calendar days** of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

At the State Fair Hearing, just like during the 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: (312) 793-2005
Email: **HFS.FairHearings@illinois.gov**
Or you may call (855) 418-4421, TTY: (800) 526-5812

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

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

State Fair Hearing Process

The hearing will be conducted by an Impartial Hearing Officer authorized to conduct State Fair Hearings. You will receive a letter from the appropriate Hearings office informing you of the date, time and place of the hearing. This letter will also provide information about the hearing. It is important that you read this letter carefully. If you set up an account at **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.
P.O. Box 27838
Albuquerque, NM 87125-9705
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.
P.O. Box 27838
Albuquerque, NM 87125-9705
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

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

Your responsibilities

- Treat your doctor and the office staff with courtesy and respect.
- Carry your Blue Cross Community Health Plans ID card with you when you go to your doctor appointments and to the pharmacy to pick up your prescriptions.
- Keep your appointments and be on time for them.
- If you cannot keep your appointments cancel them in advance.
- Follow the instructions and treatment plan you get from your doctor and agree with goals to provide better care for your health.
- Tell your health plan and your caseworker if your address or phone number or any other information changes to provide care efficiently.
- Understand your health status and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Read your member handbook so you know what services are covered and if there are any special rules.
- A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

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** (TTY/TDD: **711**).

If You Suspect Abuse, Report It

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

- If the person is enrolled in a program or lives in a setting funded, licensed or certified by DHS or lives in a private home, call the Office of the Inspector General Hotline: **1-800-368-1463**
- If the person with disabilities is enrolled in a program or lives in a setting funded, licensed or certified by DPH (e.g. nursing home) and the abuse/ neglect occurs when services are being provided, call the DPH Nursing Home Hotline: **1-800-252-4343** TTY **1-800-547-0466**
- If the abuse or neglect is to an adult 18 years and older who is not in a nursing home or a supported living facility call DOA's Hotline at **1-866-800-1409**. TTY: **1-800-358-5117**

You can also report any suspected areas of fraud or abuse to us. Please call 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**.

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

Definitions:

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

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

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

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

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

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

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

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

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

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

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

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

Integrated Health Home means a fully-integrated form of Care Coordination for all members of Illinois Medicaid. The Integrated Health Home will coordinate physical, behavioral and social healthcare for its members. An Integrated Health Home is responsible for Care Coordination for members but is not responsible for the members health services and treatment. The Integrated Health Home will work closely with your health plan to coordinate your care.

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

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

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

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

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

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

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

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

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

Privacy Policy

We have the right to get information from anyone giving you care. We use this information so we can pay for and manage your health care. We keep this information private between you, your health care provider, and us, except as the law allows. Refer to the Notice of Privacy Practices to read about your right to privacy. If you would like a copy of the notice, please call Member Services at **1-877-860-2837** (TTY/TDD: **711**).

Disclaimers

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

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

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

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

Blue Cross Community Health Plans℠

Department of Healthcare & Family Services
HealthChoice Illinois
Your Health. Your Choice.

Certificate of Coverage

WWW.BCCHPIL.COM

1-877-860-2837 /
711 (TTY/TDD)

Important Phone Numbers

24/7 Nurseline 24-hour-a-day help line	**1-888-343-2697,** TTY/TDD: **711**
Emergency Care*	**911**
Blue Cross Community Health Plans Member Services We are available 24 hours a day, seven (7) days a week. The call is free. **Website**: **www.bcchpil.com**	**1-877-860-2837,** TTY/TDD: **711**
Non-Emergency Medical Transportation	**1-877-831-3148,** TTY/TDD: **1-866-288-3133**
Behavioral Health Services	**1-877-860-2837,** TTY/TDD: **711**
Mobile Crisis Response	**1-800-345-9049,** TTY/TDD**: 711**
Grievances and Appeals	**1-877-860-2837,** TTY/TDD: **711**
Fraud and Abuse	**1-800-543-0867,** TTY/TDD: **711**
Care Coordination	**1-855-334-4780,** TTY/TDD: **711**
Adult Protective Services	**1-866-800-1409** TTY: **1-888-206-1327**
Nursing Home Hotline	**1-800-252-4343,** TTY**: 1-800-547-0466**
DentaQuest	**1-877-860-2837,** TTY/TDD: **711**
Davis Vision	**1-877-860-2837,** TTY/TDD: **711**
Illinois Department of Public Health	**1-217-782-4977**

** In an emergency, call 9-1-1 or go the nearest Emergency Department. Emergency care is covered in all of the United States.*

Certificate of Coverage

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 "the Plan" or BCCHP has contracted with the Illinois Department of Healthcare and Family Services (HFS) to provide health care coverage. Blue Cross Community Health Plans is located at 300 E. Randolph Street, Chicago, Illinois 60601.

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

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

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

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

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, call Member Services. We will help you find a doctor. If you need emergency care, go to the closest hospital. Emergency care is covered in all of the United States.

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.

Medical Services	Blue Cross Community Health Plans Benefit Limit/Exclusions	Provider Must Obtain Prior Authorization
Abortion	Abortion services are covered by Medicaid (not your MCO) by using your HFS Medical card.	Yes
Advanced Practice Nurse Services		No
Ambulatory Surgical Treatment Center Service		Yes
Annual Adult Well Exams	Exams are done by your PCP or WHCP. Physical exams are not part of family planning.	No
Assistive/Augmentative communication devices;		Yes
Audiology Services	Hearing aids are limited to one (1) hearing aid per ear every three years. Hearing screenings are only covered if you are under the age of 21. They are covered over the age of 21 if you have symptoms of an ear problem.	Yes, under certain circumstances.
Behavioral Health Services		Yes, under certain circumstances.
Blood, blood components and the administration thereof		No
Chiropractic Services	Limited to spinal manipulation for subluxation of the spine for members under 21.	No
Colorectal Cancer Screening		No
Diagnostic and Therapeutic Radiology	• Non-invasive X-rays and testing to help find out what is wrong must be ordered and done by your PCP. • Screening mammograms are not covered until age 40. You may receive one baseline mammogram after age 35. • CTs and MRIs need a prior authorization.	Yes, under certain circumstances.
Dental Services, including Oral Surgeons	For members over the age of 21: • Limited Root Canals • Limited Dentures • Limited Oral Surgery Eligible pregnant members can have these additional services covered: • Periodic oral examination • Teeth cleaning • Periodontal work	Yes, under certain circumstances.

Medical Services	Blue Cross Community Health Plans Benefit Limit/Exclusions	Provider Must Obtain Prior Authorization
Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services	Covered for enrollees under age 21. The program includes: • Physical exams • Development screenings • Lab work • Immunization • Health history and education	No
Emergency and Urgent Care Services	Call your PCP for follow-up care within **two (2) days** of your emergency, or as soon as you can. You are also required to call Member Services to let BCCHP know you received services.	No
Emergency Dental Services	Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling.	No
Emergency Transportation/ Ambulance		No
Family Planning Services and Supplies	Including but not limited to: • Doctor visit • Birth Control • Family Planning and Education • Pregnancy tests • Tests for sexually transmitted diseases (STDs) Services not included: • Fertility treatments • Surgery to reverse sterilization	No
FQHCs, RHCs and other Encounter Rate Clinic Visits		No
Gender Affirming Surgery	• Services covered for those 21 years old or older. Under specific cases of medical necessity for members under 21 • Must meet all HFS administrative rules • Requires completion of the HFS Prior Authorization for Gender-Affirming Services Form • Approval also requires letters and medical documentation from specific providers	Yes
Hearing Aids and Batteries	One hearing aid/ear every three years. Limited batteries per members	Hearing aids require prior authorization; batteries do not require prior authorization

Medical Services	Blue Cross Community Health Plans Benefit Limit/Exclusions	Provider Must Obtain Prior Authorization
Home Health Agency Visits	For non-waiver services, coverage is limited to post-hospitalization care.	Yes
Hospital Ambulatory Services		Yes
Hospital Emergency Room Visits		No
Hospital Inpatient Services		Yes
Hospital Outpatient Services		Yes, under certain circumstances.
Laboratory and X-ray Services	These services must be ordered by your provider. They must be done by a licensed provider in an appropriate place.	Yes, under certain circumstances. Genetic testing requires prior authorization. Hi tech radiology (MRI, CT, PET, etc.) requires prior authorization.
Medical supplies, equipment, prostheses and orthoses	Most Medical Equipment and Supplies covered will still need an OK from the Plan.	Yes, under certain circumstances.
Nursing Care	Covered for members under age twenty-one (21) not in the HCBS Waiver. Also, covered for individuals who are Medically Fragile, Technology Dependent (MFTD) and for members under 21 transitioning from a hospital to home placement or other setting.	Yes
Nursing Facility Services		Yes
Optical Services and Supplies	One pair of eye glasses every two years. Contact lenses only when medically necessary.	Yes
Optometrist Services	One eye exam per 12 months.	No
Palliative and Hospice Services		Yes
Pharmacy Services and Prescription Drugs	Drug limits may apply. To see if a drug is covered or if an authorization is required see the Preferred Drug List (PDL).	Yes, under certain circumstances.

Medical Services	Blue Cross Community Health Plans Benefit Limit/Exclusions	Provider Must Obtain Prior Authorization
Physical, Occupational and Speech Therapy Services		Evaluation and re-evaluation do not require prior authorization. All other physical, occupational, and speech therapy services require prior authorization.
Physician Services		No
Podiatric Services	**These services are covered:** • Medical problems of the feet • Medical or surgical treatment of disease, injury or defects of the feet • Cutting or removing corns, warts or calluses • Routine foot care **The following are not covered:** • Procedures that are still being tested • Acupuncture • Shoe inserts	No
Post-Stabilization Services		No
Practice Visits for Enrollees with Special Needs to the Dentist		No
Prostate and Rectal Exams	Prostate-specific antigen (PSA) and digital rectal exam (DRE) tests are covered for members 40 or older.	Yes, under certain circumstances.
Prosthetics and Orthotics		Yes, under certain circumstances.
Radiology Services		Yes, under certain circumstances.
Renal Dialysis Services		Yes
Respiratory Equipment and Supplies		Yes, under certain circumstances.

Medical Services	Blue Cross Community Health Plans Benefit Limit/Exclusions	Provider Must Obtain Prior Authorization
Substance Abuse	Some of the substance abuse treatments covered, include: • Detoxification • Residential Treatment • Outpatient Treatment • Medication Assisted Treatment For more information, call Member Services.	Yes, under certain circumstances.
Transplants	The first transplant is covered. Only one future re-transplant due to rejection is allowed.	Yes
Transportation (non-emergency)	Transport for non-medical reasons are not covered. Prior authorization is needed for rides that are more than 40 miles away. Also needed for providers not in network.	Yes, under certain circumstances.
Vision Services	• Eye exam is only covered once every 12 months • Eye glasses are only covered once, every two years for members 21 and older • Eye glasses are replaced “as needed” for members under 21 • Contact lenses are covered when medically necessary, if eye glasses cannot provide the intended result	Yes, under certain circumstances.

Covered Home and Community-Based Services (Waiver members only)

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

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) • Automated Medication Dispenser	You may need a prior authorization from us before you get covered services.
Department of Rehabilitative Services (DRS) ***Persons with Disabilities, HIV/AIDS***	• Adult Day service • Adult Day service Transportation • Environmental Accessibility Adaptations-Home • Home Health Aide • Nursing Intermittent • Skilled Nursing (RN and LPN) • Occupational Therapy • Home Health Aide • Physical Therapy • Speech Therapy • Homemaker • Home Delivered Meals • Personal Assistant • Personal Emergency Response System (PERS) • Respite • Specialized Medical Equipment and Supplies	You may need a prior authorization from us before you get covered services.
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.)	You may need a prior authorization from us before you get covered services.
HealthCare and Family Services (HFS) ***Supportive Living Facility***	• Assisted Living	You may need a prior authorization from us before you get covered services.

In addition to these covered services, BCCHP offers added benefits. See Page 21 in the Member Handbook for more details.

Limited Covered Services

- BCCHP may provide sterilization services only as allowed by State and federal law.
- If BCCHP provides a hysterectomy, BCCHP shall complete HFS Form 1977 and file the completed form in the Enrollee's medical record.

Non-Covered Services

- Services that are experimental or investigational in nature
- Services that are provided by a non-Network Provider and not authorized by your Health Plan
- Services that are provided without a required referral or required prior authorization
- Elective cosmetic surgery
- Infertility care
- Any service that is not medically necessary
- Services provided through local education agencies

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** (TTY/TDD **711**). We are available 24 hours a day, seven (7) days a week. The call is free.

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
- Finding out what's wrong or treating 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. 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 won't pay for services from a provider that is not part of the BCCHP network if you didn't 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.

*Some members may qualify for a 180-day transfer.

Urgent Care

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

Some examples of urgent care are:

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

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

Emergency Care

An emergency medical condition is very serious. It could even be life threatening. You could have severe pain, injury or illness. In an emergency, call 911 or go the nearest Emergency Department. Emergency Care is covered in all of the United States. Prior authorizations are not needed, but you should call your PCP and Member Services within 24 hours of your emergency care.

Some examples of an emergency are:

- Heart attack
- Severe bleeding
- Poisoning
- Difficulty in breathing
- Broken bones

Primary Care Provider (PCP) Selection

Members must choose a Primary Care Provider (PCP) from the provider directory available at the time of enrollment. The Member's PCP is responsible for providing and coordinating care, approving referrals to specialists and giving other services. Members may change their PCP by calling Member Services at **1-877-860-2837** (TTY/TDD **711**).

Access to Specialty Care

If your PCP thinks you need a specialist, they will work with you to choose an in-network specialist. Your PCP will arrange your specialty care.

If you are a woman, you have the right to select a Women's Health Care Provider (WHCP). A WHCP is a doctor licensed to practice medicine specializing in obstetrics, gynecology or family medicine. No prior authorization is needed to see a WHCP in-network.

Other Resources

To find further information about your plan, please see the table of contents on Page 5. 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 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, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

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

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

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

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

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

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

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

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

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

العربية (Arabic):

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

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

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

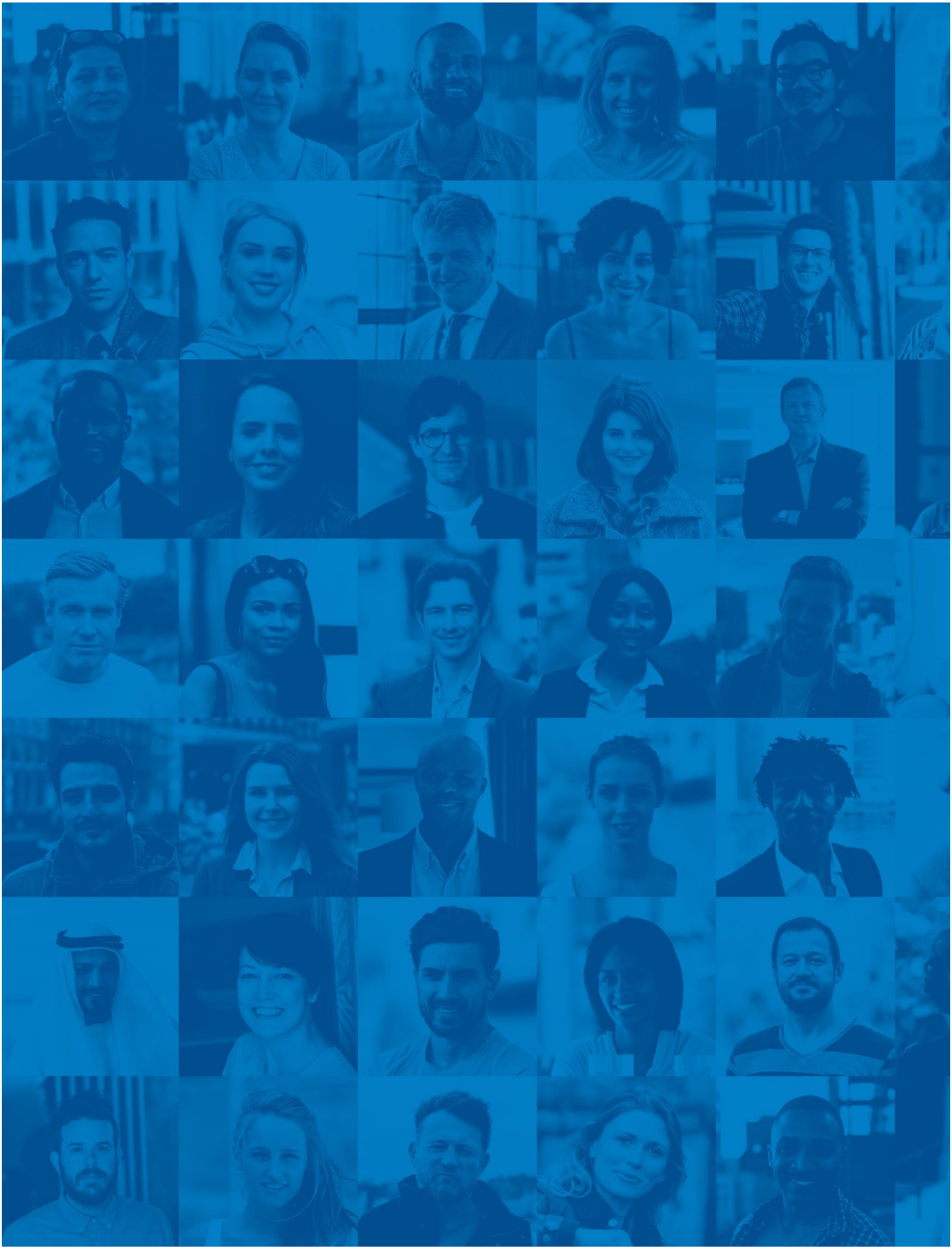
ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-860-2837 (TTY/TDD: 711).**

اُردُو (Urdu): خبردار: اگر آپ تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں

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

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

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



Blue Cross Community Health Plans℠

Department of Healthcare & Family Services
HealthChoice Illinois
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