Anthem Blue Cross
Member handbook
Benefit year 2016

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Important phone numbers

24/7 NurseLine 1-800-224-0336 (TTY 1-800-368-4424)
Americans with Disabilities Act (ADA) Information 1-800-514-0301 (TTY 1-800-514-0383)
Anthem Blue Cross Community Outreach and Engagement Department 1-800-227-3238 (TTY 1-888-757-6034)
California Children’s Services (CCS) 1-800-288-4584 (TTY 711)
California Department of Health Care Services Fraud & Abuse Hotline 1-800-822-6222 (TTY 711)
California State Department of Health Care Services (DHCS) 1-916-445-4171 (TTY 711)
California Department of Managed Health Care (DMHC) 1-888-466-2219 (TTY 1-877-688-9891)
California Department of Public Health Office of Family Planning 1-800-942-1054 (TTY 711)
California Department of Social Services (CDSS) 1-800-952-5253 (TTY 1-800-952-8349)
Care Management 1-888-334-0870 (TTY 711)
Child Health and Disability Prevention (CHDP) Compliance Officer 1-818-291-6942 (TTY 711)
Customer Care Center 1-888-285-7801 (TTY 711)
Denti-Cal 1-800-322-6384 (TTY 711)
DHCS Medi-Cal Fraud and Abuse Hotline 1-800-822-6222 (TTY 711)
Family Resource Center 1-888-525-9693 (TTY 711)
Health Care Options 1-800-430-4263 (TTY 1-800-430-7077)
Los Angeles County Department of Mental Health (LACDMH) 1-800-854-7771 (TTY 1-562-651-2549)
Los Angeles County Department of Public Health/Substance Abuse Prevention and Control (LACDPH/SAPC) 1-888-742-7900 (TTY 711)
Los Angeles County Department of Public Social Services office (DPSS) 1-866-613-3777 (TTY 1-877-735-2929)
L.A. Care 1-888-839-9909 (TTY 711)
L.A. County’s Psychiatric Mobile Response Teams (PMRT) 1-800-854-7771 (TTY 1-562-651-2549)
Medi-Cal Managed Care Office of the Ombudsman Medicare 1-888-452-8609 (TTY 1-800-896-2512)
Medicare 1-800-633-4227 (TTY 711)
Privacy & Information Security Officer 1-757-473-2737, ext. 33165
Supplemental Social Income (SSI) 1-800-772-1213 (TTY 1-800-325-0778)
U.S. Office for Civil Rights 1-866-627-7748 (TTY 1-866-788-4989)
Utilization Management 1-888-831-2246 (TTY 1-888-757-6034)
Vision Service Plan (VSP) 1-800-877-7195 (TTY 1-800-428-4833)
Women, Infants, and Children Supplemental Nutrition Program (WIC) 1-888-942-9675 (TTY 711)
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Thanks for being an Anthem Blue Cross member!
Welcome to Anthem Blue Cross! We’re here to support you, your family and your caregivers. Anthem Blue Cross is offered by the Local Initiative Health Authority for Los Angeles County (L.A. Care). L.A. Care is a health maintenance organization (HMO) that was created more than 15 years ago to help Los Angeles County Medi-Cal members get quality health care.

If you want to leave Anthem Blue Cross but stay in L.A. Care
L.A. Care works with its health care partners to provide access to health care services. They’re licensed with the State of California to serve you.

The State of California pays for your health care. There is no cost to you when you get services covered by Medi-Cal. The health plan partners work with many doctors, hospitals, pharmacies and other health care providers to provide you with quality care.

Anthem Blue Cross is responsible for almost all of your health care services. Some benefits, like dental, are not provided by Anthem Blue Cross. You can learn more about this in the What other services can I get? section of this handbook.

We think you will like Anthem Blue Cross, but staying in Anthem Blue Cross is your choice. To change your health plan for any reason, call L.A. Care at 1-888-839-9909 (TTY 711).

You can enroll in a health plan of your choice once the Los Angeles County Department of Public Social Services office (DPSS) confirms you are eligible. Enrolling in a health plan can take up to 45 calendar days.

You can start using your Medi-Cal benefits while your enrollment is being processed. Use the Identification Card (ID card) sent to you by the Department of Health Care Services (DHCS).

If you call L.A. Care at 1-888-839-9909 (TTY 711) before the 20th of the month, you can start using your new health plan benefits on the 1st of the next month. If you call L.A. Care at 1-888-839-9909 (TTY 711) on or after the 20th of the month, you can start using your new health plan benefits on the 1st of the following month. For example, if you call L.A. Care at 1-888-839-9909 (TTY 711) on June 15 to change health plans, you can start using your new health plan benefits on July 1. If you call L.A. Care at 1-888-839-9909 (TTY 711) on or after June 20 to change health plans, you can start using your new health plan benefits on August 1. When you change health plans, you will get an ID card from your new health plan. Destroy your old health plan ID card.

Some health plans do not serve all of Los Angeles County. Call the health plan to ask about their service area and to make sure it can serve you before you request a change. You will not be able to get routine care, like checkups, outside of your health plan’s service area. But do not worry: No matter which health plan you choose, you can get urgent or emergency care anywhere in the United States, Canada or Mexico when you need it. For more information, see the Emergency and urgent care: How do I get care in an emergency? section of this handbook.

If you want to leave Anthem Blue Cross and L.A. Care
You can also leave Anthem Blue Cross and L.A. Care and enroll in a different HMO at any time for any reason. To change your HMO, call Health Care Options (HCO) at 1-800-430-4263 (TTY 1-800-430-7077). When you change your HMO, you will get a new ID card and handbook from your new HMO. Destroy your old ID card.
Covered California transitions to Medi-Cal
If you and/or your family members had Covered California but now have Medi-Cal, your current provider(s) may not be part of the Anthem Blue Cross network. To learn more about this transition, please call our Customer Care Center at 1-888-285-7801 (TTY 711). They can tell you the name of your doctor or help you find a new doctor. They can also answer your questions about Anthem Blue Cross or Medi-Cal.

If you have been told you need to pay a monthly premium, go to your county office or call 1-800-880-5305 to find out more.

If you have questions about your Medi-Cal coverage or about when you need to renew, please call your Medi-Cal case worker. You can also call DPSS for more information at 1-866-613-3777 (TTY 1-877-735-2929).

Continuity of care
If you are new to Anthem Blue Cross and were required to transition to Medi-Cal, you have the right to request continuity of care. This means you keep getting services you need for up to 12 months with an out-of-network doctor. If you have been in Anthem Blue Cross for less than 12 months, you can still make this request. Retroactive requests may be accepted and approved if all continuity of care requirements are met.

We’ll begin to process your request within five business days after we receive it or within three calendar days if there is a “risk of harm”.

Continuity of care with an out-of-network provider must be granted if:
- We’re able to determine that you have an existing relationship with your out-of-network provider. An existing relationship means that you have seen the out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of your initial enrollment with Anthem Blue Cross for a nonemergency visit; and
- The provider is willing to accept the higher of our contract rates or Medi-Cal FFS rates; and
- The provider meets our applicable professional standards and has no disqualifying quality-of-care issues.

We’re not required to provide continuity of care for services not covered by Medi-Cal. Also, if your provider will not work with us, you will need to find a new provider.

You will not be eligible for continuity of care if you had the option to continue care from your previous provider but still chose to change health plans.

You can get a copy of our Continuity of Care policy by calling the Customer care center at 1-888-285-7801 (TTY 711).
This handbook: Why is it important to me?

This handbook has important information. Keep it where you can find it easily. It contains information on:

- How and from whom to get care
- What types of care are and are not covered
- Who to contact if you have problems
- Your rights as part of Medi-Cal and how you are treated

In this handbook, we use “you” and “your” to mean “the Anthem Blue Cross member.” Only the member can get the benefits mentioned in this handbook.

This handbook gives only a summary of the Anthem Blue Cross policies and rules. You must look at the contract between L.A. Care and DHCS to learn the exact terms and conditions of coverage. To get a copy of the contract, call the customer care center at 1-888-285-7801 (TTY 711).

Understanding whom to call or visit and when

Your PCP

Your PCP’s name and telephone number are on your ID card. You can call your PCP when you:

- Need an appointment
- Need a checkup
- Are sick
- Need urgent care services in Los Angeles County
- Have a health question

24/7 NurseLine

You can call the 24/7 NurseLine 24 hours a day, 7 days a week at 1-800-224-0336 (TTY 1-800-368-4424) when:

- You or a covered family member are not feeling well and you are not sure if a doctor is needed
- You have a question about a medication
- You have a general question about you or a covered family member’s health

Customer Care Center

You can call the Customer Care Center when you:

- Need a new ID card
- Want to change your PCP
- Have questions about services and how to get them
- Want to know what is covered or what is not covered
- Need help getting care
- Need a ride to a medical appointment
- Need an interpreter for your medical appointment
- Need a document from Anthem Blue Cross read in your language
- Have a problem you cannot resolve
- Get a bill from a doctor
- Want to change from Anthem Blue Cross to a different health plan or change from L.A. Care to a different HMO
- Aren’t sure who to call
Family Resource Center
Because L.A. Care is our HMO, you have access to conveniently located Family Resource Centers. The Family Resource Centers offer free exercise classes, health education classes, health screenings and a kid-friendly environment. Call 1-877-287-6290 (TTY/TDD 711) or visit http://www.lacare.org/frc for locations and more information on:

- Attending a new member orientation
- Changing health plans
- Your benefits
- Attending free health education classes

Helpful information at www.anthem.com/ca/medi-cal
Our website, www.anthem.com/ca/medi-cal, is available in English and Spanish and is a great way to learn about:

- Finding a doctor
- The 24/7 NurseLine and how and when to use it
- Your benefits
- Privacy rights
- Health education services
- Your rights and responsibilities
- Fraud, waste and abuse and how to report suspected fraud, waste and abuse
- Filing a complaint, which is called a grievance
- How and when to renew your benefits

You can also check your eligibility for medical coverage on our website. Since this information is private, you will need to log in with your member ID number.

For more information, go to www.anthem.com/ca/medi-cal and log in.
Your rights and responsibilities

Your rights
As an Anthem Blue Cross member, you have the right to:

- **Respectful and courteous treatment.** You have the right to be treated with respect and courtesy by your health plan’s providers and staff.

- **Privacy and confidentiality.** You have the right to a private relationship with your provider and a confidential medical record. You have the right to receive a copy of and request corrections to your medical record. If you are a minor, you have the right to certain services that do not need your parents’ or guardians’ approval.

- **Choice and involvement in your care.** You have the right to receive information about your health plan, its services, its doctors and other providers. You have the right to get appointments within a reasonable amount of time. You have the right to talk to your doctor about all treatment options for your condition, regardless of the cost. You have the right to say “no” to treatment and the right to a second opinion. You have the right to decide how you want to be cared for if you get a life-threatening illness or injury.

- **Make recommendations.** You have the right to make recommendations about the organization’s rights and responsibilities policy.

- Receive timely customer service. You have the right to wait no more than 10 minutes to speak to a customer service representative during Anthem Blue Cross normal business hours.

- **Voice your concerns.** You have the right to complain about Anthem Blue Cross, the health plans and providers we work with or the care you get without fear of losing your benefits. Anthem Blue Cross will help you with the process. You have the right to appeal a decision you do not agree with, which means you ask for the decision to be reviewed. You have the right to request a State Hearing (See the Complaints: What should I do if I am unhappy? section of this handbook for more details). You have the right to disenroll from your health plan whenever you want. You may also file a complaint with the Department of Managed Health Care (DMHC).

- **Service outside of your health plan’s provider network.** You have the right to receive emergency, urgent, family planning and sexually transmitted disease services outside of your health plan’s network. You can learn more about this in the Emergency and urgent care: How do I get care in an emergency? section of this handbook.

- **Service and information in your language.** You have the right to request an interpreter at no charge to you. You have the right to get all member information in your language or in another format such as audio or large print.

- **Know your rights.** You have the right to information about your rights and responsibilities.

Your responsibilities
As an Anthem Blue Cross member, you have a responsibility to:

- **Act courteously and respectfully.** You’re responsible for treating your doctor, all providers and staff with courtesy and respect. You’re responsible for being on time for your visits or calling your doctor’s office at least 24 hours before your visit to cancel or reschedule.

- **Give up-to-date, accurate and complete information.** You’re responsible for giving correct information to all of your providers and to Anthem Blue Cross. You’re responsible for getting regular checkups and telling your doctor about health problems before they become serious.

- **Follow your doctor’s advice and take part in your care.** You’re responsible for talking over your health care needs with your doctor, and developing and following the treatment plans you and your
doctor agree on.

- **Use the emergency room only in an emergency.** You’re responsible for using the emergency room in cases of an emergency or as directed by your doctor.

- **Report wrongdoing.** You’re responsible for reporting health care fraud or wrongdoing to Anthem Blue Cross. You can do this without giving your name by calling the Customer Care Center toll free at 1-888-285-7801 (TTY 711), going to www.anthem.com/ca/medi-cal, or calling the California Department of Health Care Services Medi-Cal Fraud and Abuse Hotline toll free at 1-800-822-6222 (TTY 711).
ID card

How to use your Anthem Blue Cross member ID card
You can start using your Anthem Blue Cross benefits on the 1st day of the month following completion of your enrollment in Anthem Blue Cross. This is your effective date of coverage. Check your Anthem Blue Cross ID card (mailed to you) to see your effective date of coverage.

You and every family member covered by Anthem Blue Cross received an Anthem Blue Cross member ID card. You’ll need to show your Anthem Blue Cross member ID card to access Medi-Cal services. If you did not get a member ID card for a family member who is covered, call the Customer Care Center right away.

If you have both Medicare and Medi-Cal, Medicare is your main coverage. This means that you will not be assigned a Medi-Cal PCP. You should see your Medicare doctor for your primary care needs such as:

- Doctor visits
- Hospital stays
- Prescriptions
- Lab work

Use your Anthem Blue Cross ID card for services that Medicare does not cover such as:

- Long-term stays in nursing homes
- Nonemergency medical transportation
- Some copays
- Other costs that Medicare may not cover

When you get your Anthem Blue Cross ID card:

- Check to make sure the information on your card is correct. If anything on your card is incorrect, call the Customer Care Center right away. We will connect you to DPSS to get it fixed.
- Keep your member ID card in a safe place. If you lose or damage your member ID card, call the Customer Care Center.
- Call the Customer Care Center or visit www.anthem.com/ca/medi-cal if you need to request or reorder a member ID card.

How to use your Medi-Cal card (also known as a BIC card)
The State of California sent you an ID card called the Medi-Cal Benefits Identification Card (BIC). Show your Medi-Cal card whenever you get services you do not get from Anthem Blue Cross. You can learn more about these services in the What other services can I get? section of this handbook. Call the California Department of Public Social Services toll free at 1-866-613-3777 if you need a new Medi-Cal card.

Important! Never let anyone use your health plan member ID card or Medi-Cal card. This is called fraud. You can lose your Medi-Cal benefits if someone else uses your member ID cards to get care. If you lose your Medi-Cal benefits, Anthem Blue Cross will not be able to give you care.
Our provider network
We work with a large group of doctors, specialists, pharmacies, hospitals and other health care providers. This group is called a “network.” We are proud of our doctors and their professional training. If you have questions about the professional qualifications of the network doctors and specialists, call the Customer Care Center. You can view our providers online at https://mss.anthem.com/ca/pages/find-a-doctor.aspx.

In most cases, you need to get care within our network. If you are in Mexico, Canada or outside of Los Angeles County, but still within the United States and need emergency or urgent care, you can get care outside our network. You can learn more about this in the Emergency and urgent care: How do I get care in an emergency? section of this handbook.

Your PCP
Your PCP’s job is to make sure you get the health care benefits you need and should receive. Your PCP gives you “primary” (or basic) medical care. Health care services you can get from your PCP include:

- Checkups, which are also called well-visits. This is when you go to your PCP when you are not sick, like when you need immunizations. It is important to see your PCP even when you are not sick.
- Sick care. These visits are when you see your PCP because you are not feeling well.

When you need a checkup or if you get sick, you need to go to your PCP.

If you have Medicare and Medi-Cal
Members who receive both Medicare and Medi-Cal benefits may not need to choose or be assigned a PCP. If you have both Medicare and Medi-Cal benefits, Medicare is your main coverage. You will still go to your Medicare doctors, specialists, hospitals and get most of your prescriptions from Medicare. Anthem Blue Cross will work with your Medicare PCP to determine what Medi-Cal services you may need. This handbook explains your Medi-Cal benefits through Anthem Blue Cross. Your copays, medical services and supplies that are not covered by Medicare will be taken care of by Medi-Cal if they are:

- Not covered by Medicare,
- Covered by Medi-Cal, and
- Medically needed.

If you have Medi-Cal only
You were asked to choose a PCP and a health plan partner when you filled out the Medi-Cal enrollment form. Each member has a PCP. Some exceptions may apply. Please call the Customer Care Center to learn more about these exceptions.

You may choose one PCP for all members of your family in Medi-Cal or you may choose a different PCP for each member. Women may choose an OB/GYN or family planning clinic as their PCP.

Sometimes we cannot give you the PCP you choose. Some of the reasons are:

- The PCP is not taking new patients
- The PCP does not work with the health plan you chose
- The PCP only sees patients in a specific age range or sees only women (OB/GYN)
- The PCP does not work with Anthem Blue Cross

If you did not get the PCP you chose, call the Customer Care Center to ask if he or she is available. You can
change your PCP at any time for any reason. If you did not choose a PCP within 30 days of enrolling, a PCP was assigned to you. Your PCP was chosen for you based on:

- The language you speak
- Your age and gender
- How close you live to the PCP’s office

**Who you can choose as your PCP**

You can choose your PCP from the Anthem Blue Cross provider directory that came with this handbook, or by visiting www.anthem.com/ca/medi-cal. The kinds of physicians that can be PCPs are:

- Family practitioners
- General practitioners
- Internal medicine practitioners
- Pediatricians
- OB/GYNs (for women only)

You can choose certain nonphysician providers as your PCP. These include:

- Certified nurse-midwife
- Certified nurse practitioner
- Physician assistant
- Federally Qualified Health Center (FQHC)

You have 30 calendar days from enrollment to select one of these individuals to be your PCP.

Some hospitals and other providers may have a moral objection to provide some services. To ensure you can get the health care services you need, call the Customer Care Center to get more information about the hospital or provider before you choose them.

Some hospitals and other providers do not provide one or more of the following services even if it is needed or covered by us:

- Family planning
- Contraceptive services, including emergency contraception
- Sterilization, including tubal ligation at the time of labor and delivery
- Infertility treatments
- Abortion

If a hospital or provider has religious or ethical objections to performing a procedure or otherwise service, we’ll refer you to another hospital or provider and coordinate your care, procedure or support in a timely manner.

**Changing your PCP**

It is best to stay with the same PCP because they are familiar with your health history and health needs. If you want to change your PCP, you can choose a new one from our network. Use the provider directory mailed to you along with this handbook, call the Customer Care Center or visit www.anthem.com/ca/medi-cal.

You can change your PCP for any reason if you are unhappy. Choosing the right PCP for you and your family members is important, but remember:

- Some PCPs work within a group of doctors with certain specialists, hospitals and other health care
providers. If you need a specialist, your PCP may send you to these providers. If you are going to a specialist already or want to use a specific hospital, talk with the PCP you want to choose.

- Ask about office access if you or a family member has a disability.
- In some cases, your PCP may not agree to treat you and may ask Anthem Blue Cross to make a change. This can happen if:
  - You’re disruptive or disrespectful to your doctor or your doctor’s office staff.
  - You do not follow your doctor’s treatment plan.
  - The service or care you need is not within the doctor’s scope of care such as a high-risk pregnancy.

Call the Customer Care Center to change your PCP.

**Your initial health visit**

Call your PCP today to make an appointment for a new member checkup within the first four months, or 120, days of becoming an Anthem Blue Cross member. This visit is also called an “initial health visit”.

This first visit is important. Your PCP looks at your medical history, finds out what your health status is and can begin any new treatment you might need. You and your PCP will also talk about preventive care. This is care that helps “prevent” you from getting sick or keeps certain conditions from getting worse. Remember, children also need to get a checkup every year, even when they are not sick, to make sure they are healthy and growing properly.

Please call the Customer Care Center right away if you are pregnant or become pregnant. Then, call your PCP or OB/GYN to make an appointment. You should get an appointment to see your PCP or OB/GYN within 10 calendar days from the date of your call. When you are pregnant, it is important to get care right away, throughout your pregnancy and after you give birth.

**How to make and keep an appointment**

Call your PCP’s office to schedule an appointment. You should make an appointment to see your PCP for nonurgent services within 10 business days from the date of your call. Your PCP’s phone number is on your Anthem Blue Cross member ID card. A few things to remember:

- Be on time for your appointment. If you need directions, call the PCP’s office.
- If you cannot go to your appointment, call the PCP’s office right away. By canceling your appointment, you allow someone else to be seen.
- If you miss your appointment, call right away to make another appointment.
- Show the PCP’s office your member ID card when you are there.

**Important! You can still get services without your member ID card. Your PCP, hospital or pharmacy can call the Customer Care Center to verify your membership.**

**If your PCP leaves our network**

Sometimes we stop working with a doctor, medical group or hospital. If this happens, we’ll let you know as soon as we can. You may be able to keep seeing your doctor, specialist or hospital in some situations. Call the Customer Care Center if:

- You have an acute condition. An acute condition is one that comes on quickly and lasts for a short time.
- You have a serious chronic condition. A chronic condition is a long-term, ongoing condition.
• You have an illness that will end in death.
• You have been scheduled and/or approved for surgery or a medical procedure. This must be a surgery or other procedure authorized by us as part of a documented course of treatment. This treatment must have been set to occur within 180 calendar days of the time the doctor or hospital stops working with us, or within 180 calendar days of your effective date with Anthem Blue Cross.
• You’re going to have a baby.
• You have a child up to three years old, or 36 months.

Here are some examples of when you can keep seeing your previous doctor:
• You’re seeing or have been approved to see a specialist.
• You’re waiting to see a specialist.

How to get care when your PCP’s office is closed
If you need nonemergency care when your PCP’s office is closed, such as after normal business hours, on the weekends or holidays, call your PCP’s office. You’ll get the office’s answering service. Leave your name and telephone number and a doctor will call you back.

You can also call the 24/7 NurseLine at 1-800-224-0336 (TTY 1-800-368-4424). This is available to you 24 hours a day, seven days a week, to help answer your health care questions or have your health concerns and symptoms evaluated by a registered nurse. This service is free of charge and available to you in your language.

For urgent care, such as when a condition, illness or injury is not life-threatening but needs medical care right away, call or go to your nearest urgent care center. Many Anthem Blue Cross doctors have urgent care hours in the evening, on weekends or during holidays. For emergency care, call 911 or go to the nearest emergency room. If you are not sure if it is an emergency, call the 24/7 NurseLine. Our nurses will help you decide how soon you need care.

Getting care from a provider who is not your PCP
There are some kinds of care that you can get from someone other than your PCP:
• Emergency care. In an emergency, dial 911. Emergency services do not need a referral, or an OK, from your PCP or us before you get them.
• Urgent care when you are not in Los Angeles County and cannot come back to Los Angeles County to get care. Call your PCP if you are not sure how to get urgent care when you are not in Los Angeles County.
• Family planning services and sexually transmitted disease testing. You may get these services from any health care provider licensed to provide these services. You do not need your PCP’s OK to get these services.
• Specialist care. Your PCP will send you to a specialist if you need one. In most cases, you cannot see a specialist without your PCP’s approval.
• Behavioral health care. You do not need a referral from your PCP to get behavioral health care.

Members may see an in-network OB/GYN for OB/GYN services without the PCP’s OK.

How to get health care your PCP cannot give you
Sometimes you need care your PCP cannot give you. You may need care from a specialist or a hospital. To see
a specialist or get treatment at a hospital, your PCP must OK the care, and give you a referral. A referral is a request from your PCP to another doctor or to a hospital to provide health care services or treatment you need. Your PCP will start the referral process but you must get a referral before you get specialized health care services or treatment.

Routine referrals take up to five business days to process. Business days are Monday through Friday, excluding holidays. Routine referrals may take longer if more information is needed from your PCP. In some cases, your PCP may ask to expedite, or rush, your referral. Rush referrals must not take more than three calendar days. Please call the Customer Care Center if you do not get a response within these time frames.

If a referral is not approved, you will receive a letter from your PCP or Anthem Blue Cross explaining why the referral was denied. If you do not agree with the explanation given, you may file a complaint. For information on how to file a complaint, turn to the Complaints: What should I do if I am unhappy? section of this handbook.

How to get care from a specialist
Sometimes your PCP will send you to a specialist. (A “specialist” is a doctor who is an expert in a certain kind of health care). These specialists work with your PCP and are part of our network. If you need care from a specialist, your PCP must approve these services before you receive them. Routine referrals to a specialist may take up to five business days, but may take longer if more information is needed from your PCP. In some cases, your PCP may ask to “rush” your referral. Expedited (rush) referrals (for when you need medical care right away or have an urgent condition) may not take more than three calendar days.

Female members who need OB/GYN care do not need their PCP’s approval to go to an OB/GYN or family planning doctor that works with Anthem Blue Cross.

If you need to see an OB/GYN or need to get emergency or urgent care, you do not need a referral. Emergency or urgently needed services are covered 24 hours a day, seven days a week anywhere in the United States, Canada and Mexico. Referrals are never needed for emergency or urgently needed services or OB/GYN care.

How to get a standing referral with a specialist
You may need to see a specialist or another qualified health care professional for a long time if you have a chronic disease such as diabetes or asthma, a life-threatening condition such as HIV/AIDS or a disability. This is called a “standing referral.” A standing referral is made to a specialist who is in our network or a contracted specialty care center. If there is not a qualified specialist in our network, we’ll send you to a specialist outside of our network.

You or your PCP must get an OK from us for a standing referral. Your PCP can ask on your behalf.

We must OK or deny your request for a standing referral within three business days. Once you have a standing referral, you will not need to ask us for an OK again for that same referral.

Your specialist will develop a treatment plan for you that’ll show how often you need to go to the doctor. Once your treatment plan is approved, your specialist will coordinate the care you get. This specialist will have permission to provide health care services the same way your PCP does.
What’s a second opinion?
You have the right to ask for and get a second opinion at no cost to you. A second opinion is a visit with another doctor when:

- You question a diagnosis for a chronic condition or for a condition that endangers your life or body. A diagnosis is when a doctor identifies a condition, illness or disease.
- You do not agree with your PCP or specialist’s treatment plan. A treatment plan is what the doctor says is best for you, based upon the doctor’s diagnosis.
- You want to make sure your treatment plan is right for you.

The second opinion must be from a qualified health care professional in the Anthem Blue Cross network. A qualified health care professional is a person who has the training and expertise to treat or review a specific medical condition.

If there is no qualified health care professional in our network, then we’ll authorize, or OK, a second opinion by a qualified health care professional outside our network.

How to get a second opinion
To get a second opinion:
1. Talk to your PCP, specialist or Anthem Blue Cross and let them know you want to see another PCP and why.

2. Your PCP, specialist or Anthem Blue Cross will refer you to a qualified health care professional. If you are requesting a second opinion about a diagnosis that your PCP made, the second opinion must be from a PCP of your choice from the same physician organization as your PCP’s.

   If you are requesting a second opinion about a diagnosis that your specialist made, a second opinion must come from any independent physician association (IPA) or medical group within our network for the same specialty.

   If there is no qualified health care professional within our network, Anthem Blue Cross will OK a second opinion by a qualified provider outside the network.

3. Call the second opinion doctor to make an appointment. Show the doctor’s office your member ID card.

You may file a complaint if we deny your request for a second opinion or if you do not agree with the second opinion. This is called “filing a grievance.” You can learn more about this in the Complaints: What should I do if I am unhappy? section of this handbook.

Care outside of Anthem Blue Cross’ network
As a member of Anthem Blue Cross, your service area is Los Angeles County. For routine or regular care, all health care services are provided in Los Angeles County. Routine care outside of L.A. County is not covered. In most cases, you need to get care within our network and within Los Angeles County.

If you get care from a doctor or other provider that is not part of our network or one who is outside of Los Angeles County, you may be billed by the provider and you may have to pay. You will not have to pay if you receive emergency care, urgent care, HIV testing and counseling, family planning or sexually transmitted
disease (STD) testing services outside of our network. You can learn more about this in the Emergency and urgent care: How do I get care in an emergency? section of this handbook.

If you get a bill
Anthem Blue Cross pays for all medical costs covered by Medi-Cal for emergency care. You should not get a bill for any services covered by Anthem Blue Cross. Please call the Customer Care Center right away if you receive a medical bill.

You may get a medical bill if you go to a doctor or hospital that does not work with Anthem Blue Cross or is located outside of L.A. County. If this happens, you may have to pay for services that are not covered by Anthem Blue Cross. If you pay the bill, keep a copy or record of your payment and send a copy of your payment to Anthem Blue Cross for review. If the bill is for covered or authorized services, you may receive a refund.

You should not be billed for emergency care, urgent care, the care required to stabilize an emergency condition, family planning services or for sexually transmitted disease testing at a clinic. You should not be billed for hospital care you get due to an emergency. If you get a bill, do not pay it. Call the Customer Care Center right away.

Do not pay medical bills you get from a collection company. If you get a bill for covered services and need help, or if you want to file a complaint, call the Customer Care Center. If you had Medi-Cal at the time of your visit, you cannot be charged for covered medical services. Your doctor must tell the collection company to stop trying to make you pay the bill.
Services covered by us
In order for you to get any health care service through Anthem Blue Cross, the service must be both:
- A covered benefit in Medi-Cal — a service we pay for because it is a Medi-Cal or Anthem Blue Cross plan benefit; and
- Medically necessary — you need the service to get healthy or stay healthy

All health care services are reviewed, changed, approved or denied according to medical necessity. If you would like a copy of the policies and procedures we use to decide if a service is medically necessary, call the Customer Care Center. No doctor has to give you services that he/she does not believe you need. Services are subject to all terms, conditions, limits and exclusions.

All services require prior authorization, or an OK from us, unless the benefit provisions say otherwise.

Services that do not require prior authorization are:
- PCP visits
- Emergency services
- Urgently needed services when outside of Los Angeles County
- Family planning services
- Preventive services
- Sexually transmitted disease (STD) services
- HIV testing
- Basic prenatal care from an in-network doctor
- In-network certified nurse-midwife/OB/GYN services

Call the Customer Care Center if you have questions about:
- Your benefits
- How or where to get benefits
- What is covered or not covered

All covered benefits are free. Some exceptions may apply. Please call the Customer Care Center to learn more about these exceptions.

Alcohol misuse
We cover alcohol misuse screening services for all members 18 and older. Services include:
- Behavioral counseling intervention
- Health education services
- Screening, brief intervention and referral to treatment

Asthma services
- Nebulizers (including face mask and tubing), inhaler spacers and peak flow meters for management and treatment of asthma
- Member education on proper use of asthma equipment
- Member education for self-management and group education classes offered at Family Resource Centers
Behavioral health treatment for Autism Spectrum Disorder

We cover behavioral health treatment (BHT) for autism spectrum disorder (ASD). This treatment includes applied behavior analysis and other evidence-based services. This means the services were reviewed and shown to work. The services should develop or restore, as much as possible, the daily functioning of a member with ASD.

BHT services must be:
- Medically necessary; and
- Prescribed by a licensed doctor or a licensed psychologist; and
- Approved by the Plan; and
- Given in a way that follows the member’s approved treatment plan

You may qualify for BHT services if:
- You’re under 21 years of age; and
- You were diagnosed with ASD; and
- Your behavior interferes with home or community life. Some examples include anger, violence, self-injury, running away or difficulty with living skills, play and/or communication skills

You do not qualify for BHT services if you:
- Are not medically stable; or
- Need 24-hour medical or nursing services; or
- Have an intellectual disability (ICF/ID) and need procedures done in a hospital or an intermediate care facility

If you are currently receiving BHT services through a regional center, the regional center will continue to provide these services until a transition plan is developed. Further information will be available at that time.

You can call the Customer Care Center if you have any questions or ask your PCP about screening, diagnosis and treatment of ASD.

Cancer clinical trials

If you have cancer, you could be part of a cancer clinical trial. A cancer clinical trial is a research study with cancer patients to find out if a new cancer treatment or drug is safe and treats a specific type of cancer. The cancer clinical trial must meet certain requirements. It must:
- Have a meaningful potential to benefit you; and
- Be approved by one of the following:
  - The National Institute of Health (NIH); or
  - The Food and Drug Administration (FDA); or
  - The U.S. Department of Defense; or
  - The U.S. Veterans Administration

If you are part of an approved cancer clinical trial, we’ll provide coverage for all routine patient care costs related to the clinical trial.

If you have a life-threatening condition or were eligible but denied coverage for a cancer clinical trial, you have
the right to request an Independent Medical Review (IMR). You can learn more about this in the **Complaints: What should I do if I am unhappy?** section of this handbook.

**Cancer screening**
All medically accepted cancer screening tests, including coverage for screening and diagnosis of prostate cancer and the following are covered:

- Colon cancer screening and diagnosis with options of at-home screening kits like a Fecal Occult Blood Test, flexible sigmoidoscopy, and/or colonoscopy exam
- Mammography for screening/diagnostic purposes
- Cervical cancer screening test and prevention, including:
  - Papanicolaou (Pap) test
  - Human papillomavirus (HPV) screening
  - HPV vaccinations

**Diabetic services**
These services are covered for diabetic patients when medically necessary:

- Medical equipment
- Prescription drugs in our formulary
- Diabetes-related supplies:
  - Blood glucose monitors and testing strips
  - Blood glucose monitors designed to assist the visually impaired for insulin-dependent, non-insulin-dependent and gestational diabetes
  - Insulin pumps and all related necessary supplies
  - Ketone urine testing strips
  - Lancets and lancet puncture devices
  - Pen delivery systems for the administration of insulin
  - Podiatric devices of the feet such as special footwear or shoe inserts to prevent or treat diabetes-related complications
  - Insulin syringes
  - Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
  - Health education for self-management and group education classes offered at the Family Resource Centers
  - Family education about the diabetic disease process and daily management

**Doctor’s office visits**
All routine visits, exams, treatments, required immunization shots and Child Health and Disability Prevention Program (CHDP) visits are provided by your doctor.

**Specialist services**
Any CHDP services from school-based programs or the Los Angeles County Department of Health Services are covered. For more information, see the **What other services can I get?** section of this handbook. You can also call CHDP at 1-800-993-2437.

**Drugs/medications**
Prescription drugs and over-the-counter drugs in our formulary are covered. You can learn more about this in
the Pharmacy benefits: How do I get prescription drugs? section of this handbook.

Durable medical equipment (DME)
DME is medical equipment used repeatedly, or over and over again, by a person who is ill or injured. These items are ordered by your doctor. Examples include:

- Apnea monitors
- Blood glucose monitors, including monitors for the visually impaired for insulin-dependent, non-insulin-dependent and gestational diabetes
- Insulin pumps and all related supplies
- Nebulizer machines
- Orthotics or shoe inserts
- Ostomy bags
- Oxygen and oxygen equipment
- Prosthesis
- Pulmo-aides and related supplies
- Spacer devices for metered-dose inhalers
- Tubing and related supplies
- Urinary catheters and related supplies

To find out what other items are on the approved DME list, please call the Customer Care Center. You could get other items not on the list if they are covered and are medically necessary.

Emergency services
Emergency services are covered 24 hours a day, seven days a week. No services are covered outside of the United States except for emergency services in Canada and Mexico. Emergency care is a service that a member reasonably believes is necessary to stop or relieve:

- Severe pain
- Sudden serious illnesses or symptoms
- Injuries or conditions requiring immediate diagnosis and treatment, including emergency labor and delivery

Emergency services and care include:

- Ambulance
- Medical screening
- Examination
- Evaluation

Emergency services include:

- Services for both physical and psychiatric emergency conditions
- Active labor
- Services for conditions that would place a pregnant woman or her unborn child in serious jeopardy

You can learn more about these in the Emergency and urgent care: How do I get care in an emergency? section of this handbook.
Family planning
We provide family planning services to help delay or prevent pregnancy. These services include all methods of birth control approved by the Food and Drug Administration (FDA). You may receive family planning services and FDA-approved contraceptives from any health care provider licensed to provide these services.

Examples of family planning providers include:
- Your PCP
- Clinics
- Certified nurse-midwives and certified nurse practitioners
- OB/GYN specialists, who’re doctors who specialize in female reproductive health care
- Planned Parenthood clinics

Family planning services also include pregnancy tests, counseling and surgical procedures for the termination of pregnancy, which is also called an abortion. Please call the Customer Care Center to find out more.

Many of our doctors who provide family planning services are also OB/GYN specialists. Women may choose a PCP from a list of family planning clinics located near them. Call the Customer Care Center for a copy of this list.

Women have the right to family planning services given by a family planning provider who is not in our network. You do not need an OK from your PCP to do this. We’ll pay that PCP or clinic for the family planning services you get.

The California Department of Public Health Office of Family Planning can also answer questions or give you a referral for family planning services. You can reach them at 1-800-942-1054 (TTY 711).

Health education services
Our Health Education program services include wellness classes and group appointments to help you stay healthy and manage your chronic conditions. Health education is offered in English and Spanish at convenient places and times for you. We also provide interpreter services for languages other than Spanish at no cost to you.

If you cannot make it to a class or appointment, an Anthem Blue Cross health educator will call you and talk to you over the phone. Some health topics include asthma, diabetes, heart health, chronic condition support, nutrition and exercise.

Health education resources include written materials, community referrals, online information, CDs/DVDs or videos and the 24/7 NurseLine. Resources are available in multiple languages for many health topics.

All health education services and resources are provided at no cost to you. Call the Customer Care Center for more information.

You can also access health information, health tips and other resources through www.anthem.com/ca/medi-cal.

Hearing aids
Hearing aids are covered when ordered by your doctor.

**HIV/AIDS testing**
You can get private HIV testing from any health care provider licensed to provide these services and that accepts Medi-Cal. You do not need a referral or OK from your PCP or health plan. Examples of where you can get confidential HIV testing include:
- Your PCP
- Los Angeles County Department of Health Services
- Family planning services providers
- Prenatal clinics

Please call the Customer Care Center to request a list of testing sites.

If you need treatment for HIV/AIDS, you must see a doctor that is in our network.

**Home health care**
Home health care services are provided in the home if the following are met:
- You are homebound
- You require help from a nurse, physical, occupational or speech therapist
- Services can be provided and monitored in a safe way in your home

Home health services ordered by your doctor are provided by home health personnel such as:
- Registered nurses
- Licensed vocational nurses
- Home health aides
- Medical social services

If a service can be provided in more than one location, we’ll work with the provider to choose the location.

**Hospice care**
Hospice care is limited to members who have been certified as terminally ill. This means that, if the illness continues as expected, the member’s life expectancy is six months or less. If you decide to receive hospice benefits, you are waiving all rights to all other benefits for the terminal illness for the duration of the hospice election. You can change your choice to receive hospice care at any time. The hospice election may be made of up to two periods of 90 days each and an unlimited number of subsequent periods of 60 days each during the individual’s lifetime.

If you are under the age of 21, we’ll offer and pay for covered services related to your terminal illness even if you choose to receive hospice care. California Children’s Services (CCS) will continue to pay for covered services.

**Hospital care**
Includes but is not limited to:
- Inpatient services
- Intensive care
Outpatient services
• Surgical services such as bariatric, reconstructive surgery, etc.
• Incontinent creams and washes

These are provided at no cost when there is a medical need.

**Laboratory and imaging services**
Outpatient laboratory services are covered, such as:
• Blood work
• Urine tests
• Throat cultures

Imaging services to help your PCP diagnose and treat your condition include:
• X-rays
• MRIs
• CT scans
• PET scans

Some advanced imaging services are covered based on medical necessity and may require an OK from Anthem Blue Cross.

Services must be obtained at a network provider:
• Doctor’s office
• Hospital
• Laboratory

**Managed long-term services and supports (MLTSS)**
Some MLTSS benefits are covered for members who qualify.

Covered services include:
• Community Based Adult Services (CBAS). CBAS is a program you may qualify for if you have health problems that make it hard for you to take care of yourself. If you qualify, we’ll help you find a CBAS center that best meets your needs. If there is no center available in your area, Anthem Blue Cross will make sure you get the services you need from other providers. At the CBAS center, you can get different services. They include:
  o Skilled nursing care including medication management
  o Social services
  o Meals (nutritious breakfast, lunch and afternoon snacks including dietary consultation)
  o Physical therapy
  o Speech therapy
  o Occupational therapy
  o Transportation

CBAS centers also offer training and support to your family and/or caregiver. You may qualify for CBAS if:
• You used to get these services from an Adult Day Health Care (ADHC) center
Your primary care doctor refers you to Anthem Blue Cross for CBAS
You are referred for CBAS by a hospital, skilled nursing facility, community agency and/or a social worker/case manager

- Multi-Purpose Senior Services Program (MSSP) – You may qualify for MSSP services if you are 65 years or older, have a disability and are eligible for nursing facility placement but wish to remain at home. If approved, an MSSP provider will help you access services to help you remain safely at home. Services provided by MSSP may include:
  - Adult day care/support center
  - Housing assistance
  - Chore and personal care assistance
  - Protective supervision
  - Care management
  - Respite
  - Transportation
  - Meal services
  - Communication services.

- In-Home Supportive Services (IHSS). If you have a disability, are blind or are over 65 years of age and unable to live at home without help, you may qualify for IHSS benefits. IHSS allows you to hire a caregiver to help you with your daily needs so you can remain safely in your own home. IHSS benefits may include the following services:
  - Meal preparation and cleanup
  - Laundry
  - Personal care services (such as bowel and bladder care, bathing, grooming and paramedical services)
  - Grocery shopping and errands
  - Transportation to medical appointments
  - Household and yard cleaning
  - Protective supervision
  - Accompaniment to medical appointments

**Mastectomy for breast cancer**

Mastectomy is a surgery to remove all or part of a breast, due to cancer. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins. A mastectomy may include the following to restore or achieve symmetry after a mastectomy:

- Prosthesis (replacing a missing body part with an artificial one)
- Reconstructive surgery (see “Reconstructive surgery” in this section for more information)

If you have your surgery in a hospital, you and your doctor will decide how long you need to stay in the hospital after the surgery based on medical necessity.

**Maternity and prenatal care**

Maternity and prenatal care includes:

- Regular PCP visits during your pregnancy (called prenatal visits)
- Prenatal supplements
- Diagnostic and genetic testing
• Nutrition counseling
• Labor and delivery care
• Health care six weeks after delivery (called postpartum care)
• Inpatient hospital care for at least 48 hours after normal vaginal deliveries or for at least 96 hours after a Cesarean section. Coverage for inpatient hospital care may be less than 48 hours or 96 hours if:
  o The decision is made by the mother and treating physician and
  o A post-discharge follow-up visit for the mother and newborn is made within 48 hours of discharge

After giving birth, you will receive breastfeeding education and special equipment if needed. Ask your doctor, or call the Customer Care Center if you have any questions.

If you are pregnant, call the Customer Care Center right away. We want to make sure you get the care you need. Anthem Blue Cross will help you find a maternity care doctor in your network. Ask your PCP to find out more.

Go to “Women, Infants, and Children Program (WIC)” under the What other services can I get? section of this handbook for information about nutrition and food stamps.

Minor consent services
There are some services adolescent members (12 to 21 years of age) can get without a parent’s OK. Minors can decide to get these services through their PCP or from other qualified providers not with Anthem Blue Cross’ network.

The following services are covered:
• Counseling and surgical procedures to end pregnancy (abortion)
• Drug and alcohol abuse services for members 12 years of age or older
• Family planning
• Pregnancy-related services
• Sexual assault treatment (including rape)
• Sexually transmitted disease (STD) services for members 12 years of age or older including consenting to medical care to prevent a sexually transmitted disease
• Outpatient mental health treatment and counseling for minors (12 to 21 years of age) who are mature enough to participate, and if:
  o There is a danger of serious physical or mental harm to themselves or to others; or
  o They are a victim of incest or child abuse.

Newborn care
Your newborn baby will be covered by Anthem Blue Cross for the month of birth and the following month.

When you have a baby, it is important to do three things:
• Please call the Customer Care Center. We want to make sure you and your baby get the care you need right away.
• Contact your eligibility worker at DPSS toll free at 1-866-613-3777 (TTY 1-877-735-2929) to enroll your baby in Medi-Cal. This is important so that your baby can continue to get Medi-Cal benefits!
• Take your baby to the doctor within three days of getting home from the hospital after delivery. An Anthem Blue Cross doctor in your network should see your newborn baby within a few days of the
Newborn baby screenings for certain treatable genetic disorders are covered. These genetic disorders include, but are not limited to:

- Phenylketonuria (PKU). Treatment of PKU includes medically prescribed formulas and special food products. PKU cases are followed by a health care professional who consults with a doctor specializing in PKU-related diseases.
- Galactosemia
- Hypothyroidism
- Hemoglobinopathies
- Sickle cell disease
- Thalassemia
- Amino acid disorders
- Organic acid oxidation disorders
- Fatty acid oxidation disorders
- Congenital adrenal hyperplasia (CAH)
- Related blood disorders

Babies with these conditions will be referred to CCS for treatment or to Anthem Blue Cross if the treatment is not covered by CCS.

**Obstetrical/gynecological (OB/GYN) care**

Members do not need a referral or OK from their PCP or Anthem Blue Cross to see an OB/GYN who works in our network. Please call the Customer Care Center if you have any questions.

**Outpatient mental health service**

Outpatient mental health services are a benefit covered by Anthem Blue Cross Health Plan. You can call the Customer Care Center Health Plan or ask your PCP for the name of a mental health provider. These services are for the treatment of mild to moderate mental health conditions, which include:

- Individual and group mental health testing and treatment (psychotherapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services that include lab work, drugs and supplies
- Outpatient services to monitor drug therapy
- Psychiatric consultation
- Screening, brief intervention and referral to treatment

For mental health services, please call the Customer Care Center. No-cost interpreting services, including American Sign Language, are available. You can still get specialty mental health services for severe mental health conditions from the Los Angeles County mental health plan.

**Podiatry care (services for the feet)**

Podiatry services are limited to two visits per month at a hospital outpatient department, an organized outpatient clinic, a federally qualified health center or rural health clinic. Podiatry care requires prior authorization except when received on an emergency basis.
Reconstructive surgery
Anthem Blue Cross covers reconstructive surgery to correct or repair problems with parts of the body that are caused by birth defects, abnormal development, trauma, infection, tumors or disease. These services are covered if your doctor finds that they will help your body work better, or give you a more normal look.

Sexually transmitted disease (STD) services
STD services include:
- Preventive care
- Screening
- Testing
- Diagnosis
- Counseling
- Treatment
- Follow-up

You can get confidential STD services from any doctor or clinic that accepts Medi-Cal. You do not need a referral from your doctor. Anthem Blue Cross will pay for the covered services you get.

Skilled nursing facility services
Skilled Nursing Facilities (SNF) services may be available to you if you are physically disabled and require a high level of care. SNF services must be prescribed by your doctor or certified nurse practitioner and provided in a licensed SNF. Covered services include:
- Skilled nursing care on a 24-hour-per-day basis
- Bed and board (daily meals)
- Case management
- X-ray and laboratory procedures
- Physical, speech and occupational therapy
- Prescribed drugs and medications
- Medical supplies
- Durable medical equipment if generally furnished by the SNF

Substance use disorder preventive services
Alcohol misuse screening services are now a benefit covered by Anthem Blue Cross Health Plan for all members ages 18 and older. These services for alcohol misuse cover:
- One expanded screening for risky alcohol use per year
- Three 15-minute brief intervention sessions to address risky alcohol use per year

Anthem Blue Cross Health Plan does not cover services for major alcohol problems, but you may be referred to the Los Angeles County Department of Public Health/Substance Abuse Prevention and Control (LACDPH/SAPC) with or without a referral from your PCP. LACDPH/SAPC can be reached toll free at 1-888-742-7900 (TTY 711).

Temporomandibular joint (TMJ) disease
TMJ disease is covered only for medically necessary surgery or treatment to realign the jaw and not for a dental disorder.
Therapy – Occupational, physical and speech

Occupational therapy is used to improve and maintain a patient’s daily living skills after a disability or injury.

Physical therapy uses exercise to improve and maintain a patient’s ability to function after an illness or injury.

Speech therapy is used to treat speech problems.

Topical fluoride varnish

Topical fluoride varnish helps prevent and control tooth decay. Topical application of fluoride is a Medi-Cal benefit for children younger than six years of age, up to three times in a 12-month period.

Transgender services

These services are provided when medically necessary and may include:

- Psychotherapy
- Continuous hormonal therapy
- Laboratory testing to monitor hormone therapy
- Gender reassignment surgery that is not cosmetic in nature

Transportation

- Emergency transportation is covered for a member who believes it is necessary to stop or relieve sudden serious illnesses, symptoms, injury or conditions requiring immediate diagnosis and treatment. Emergency transportation or ambulance transport services provided through the "911" emergency response system will be covered in a medical emergency when a member believes it was medically necessary.
- Nonemergency medical transportation to medical facilities is covered when your medical and physical condition does not allow you to take regular means of public or private transportation (car, bus, etc.) and you have a written approval from your doctor. Examples of nonemergency medical transportation include, but are not limited to, litter/gurney vans, wheelchair vans, and ambulance. Also includes nonemergency transportation for the transfer of a member from a hospital to another hospital or facility, or facility to home.
- Nonemergency medical transportation is provided when the transportation is:
  - Medically necessary; and
  - Requested by the PCP; and
  - Authorized in advance by Anthem Blue Cross

In addition, Anthem Blue Cross may provide members with nonmedical transportation. Nonmedical transportation is the transport of members to services and appointments by passenger car or taxi cabs. If you need nonemergency medical transportation or nonmedical transportation, please call your doctor, or Anthem Blue Cross. You must have approval to get these services before the services are given. No-cost interpreting services, including American Sign Language, are available to assist you with your transportation benefit.

Exclusion: Coverage for nonemergency public transportation, including transportation by airplane, passenger car, taxi, etc. is excluded. Transportation is not covered if the care or services to be obtained are not a Medi-Cal benefit.
Vision care
Eye exams are covered by Anthem Blue Cross for members of all ages. Members who are under 21 years of age, pregnant or living in a nursing home are covered for one pair of eyeglasses every two years unless the prescription changes. This includes lenses and covered frames for eyeglasses when authorized.

To find out more about eye exams or vision care coverage, call Vision Service Plan (VSP) toll free at 1-800-877-7195 (TTY 1-800-428-4833). No-cost interpreting services, including American Sign Language, are available.

Care Management
Care management is a no-cost service we offer to help you keep track of your health care needs. Our nurses, social workers and other trained staff are ready to help you with complicated problems that affect your health. You can call your care manager with questions about:

- Your health care
- Getting behavioral health (mental health and substance use disorder) service
- Other services that might help improve your health

Your provider may refer you to us or we might call you. If you think you need care management services, please call the Customer Care Center and we’ll refer you to the Care Management department. If you are concerned about a new diagnosis or a change in your health or your child’s health or you want to change your care manager, please call 1-888-334-0870 (TTY 711). Ask to speak with a registered nurse (RN) or social worker case manager.

Disease Management Centralized Care Unit
If you have a long-term health issue, you do not have to go it alone. Our disease management program can help you get more out of life. The program is voluntary, private and on hand at no cost to you. It is called the Disease Management Centralized Care Unit (DMCCU) program. A team of licensed nurses and social workers, called DMCCU case managers, are available to teach about your health issue and help you learn how to manage your health. Your primary care provider (PCP) and our DMCCU team are here to help you with your health care needs.

You can join the program if you have one of these conditions:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder
- Schizophrenia
- Substance use disorder

We also offer weight management services.

DMCCU case managers work with you to make health goals and help you build a plan to reach them. As a member in the program, you will benefit from having a case manager who:

- Listens to you and takes the time to understand your specific needs.
- Helps you make a care plan to reach your health care goals.
• Gives you the tools, support and community resources that can help you improve your quality of life.
• Provides health information that can help you make better choices.
• Assists you in coordinating care with your providers.

As an Anthem Blue Cross member enrolled in the DMCCU program, you have certain rights and responsibilities.
You have the right to:
• Have information about Anthem Blue Cross; this includes all Anthem Blue Cross programs and services as well as our staff’s education and work experience; it also includes contracts we have with other businesses or agencies.
• Refuse to take part in or leave programs and services we offer.
• Know which case manager is handling your disease management services, as well as how to ask for a change.
• Have Anthem Blue Cross help you to make choices with your doctors about your health care.
• Learn about all DMCCU-related treatments; these include anything stated in the clinical guidelines, whether covered by Anthem Blue Cross or not; you have the right to talk about all options with your doctors.
• Have personal data and medical information kept private.
• Know who has access to your information and know our procedures used to ensure security, privacy and confidentiality.
• Be treated with courtesy and respect by Anthem Blue Cross staff.
• File complaints to Anthem Blue Cross and receive guidance on how to use the complaint process, including our standards of timeliness for responding to and resolving issues of quality and complaints.
• Receive information that is clear and easy to understand.

You are encouraged to:
• Follow health care advice offered by Anthem Blue Cross.
• Give Anthem Blue Cross information needed to carry out our services.
• Tell Anthem Blue Cross and your doctors if you decide to disenroll from the DMCCU program.

If you have one of these health issues or would like to know more about our DMCCU, please call 1-888-830-4300 Monday through Friday from 8:30 a.m. to 5:30 p.m. local time. Ask to speak with a DMCCU case manager. You can also visit our website at www.anthem.com/ca/medi-cal or call the DMCCU if you would like a copy of DMCCU information you find online. Calling can be your first step on the road to better health.
What other services can I get?
Medi-Cal members are entitled to other health care benefits and services that are not provided by Anthem Blue Cross.

California Children’s Services (CCS)
CCS is for people under the age of 21 with a disability. If your child has a chronic (long-term) medical illness, your child may be eligible for services under CCS.

Anthem Blue Cross will identify children with CCS-eligible conditions, arrange for a referral to the local CCS office and continue to provide case management until eligibility is established with the CCS program. Primary care services will continue to be provided by Anthem Blue Cross.

Please call the Customer Care Center if your child is getting CCS services. Anthem Blue Cross can arrange for your child to continue getting services as a member of Anthem Blue Cross. You can call the Los Angeles County CCS office toll free at 1-800-288-4584 (TTY 711) to find out more.

Child Health and Disability Prevention (CHDP)
Your child may get CHDP preventive services through his or her local school. These services help keep children from getting sick and include regular checkups, immunizations (shots), education and counseling and vision and hearing tests.

You may call CHDP at 1-800-993-CHDP (1-800-993-2437) if you have any questions.

Women, Infants, and Children Program (WIC)
The Women, Infants, and Children Supplemental Nutrition Program (WIC) gives pregnant women and new mothers nutrition information and coupons to buy healthy foods. Ask your doctor or maternity nurse to find out more about WIC. You may call WIC directly at 1-888-942-9675 (TTY 711).

Special services for American Indians
American Indians have the right to get health care services at Indian Health Centers and Native American Health Clinics. They may also stay with or disenroll from Anthem Blue Cross while getting health care services from these locations. American Indians have a right to not enroll in a Medi-Cal managed care plan or may leave their health plans and return to regular (fee-for-service) Medi-Cal at any time and for any reason. To find out more, please visit the Indian Health Services website at www.ihs.gov.

Additional benefits from Anthem Blue Cross
Anthem Blue Cross provides five more benefits to our members, including those 21 and older:

- Speech therapy services
- Podiatry (foot) services if you are in a hospital outpatient department, at an organized outpatient clinic, at a federally qualified health center or rural health clinic
- Audiology (hearing) services
- Incontinence creams and washes
- Annual optometry (eye) exam for diabetic members
Services you cannot get because of age
If you are age 21 or older, the following services are not covered by Anthem Blue Cross:

- Dental
- Chiropractic
- Eyeglasses

Services you can get through Medi-Cal but not Anthem Blue Cross
Some services are not covered by Anthem Blue Cross but you can get them through Medi-Cal or another state program:

- Alcohol and drug treatment services (outpatient), except for Screening, Brief Intervention and Referral to Treatment for alcohol misuse, as described in the Services covered by us section of this handbook.
- Childhood lead poisoning (through the Los Angeles County Department of Health Services)
- Chiropractic services
- Direct Observed Therapy for the treatment of tuberculosis (through the Los Angeles County Department of Health Services)
- Dental services that are normally done by a dentist, orthodontist or oral surgeon and dental appliances. You must get dental services through Denti-Cal. Call 1-800-322-6384 (TTY 711) to learn more. Anthem Blue Cross covers dental screenings under the first health checkup and will refer members to Medi-Cal dental providers. Anthem Blue Cross covers the following when medically necessary:
  - Prescription drugs
  - Lab services
  - Outpatient surgical services
  - Inpatient services
  - General anesthesia for dental work is covered for members under seven years of age, the developmentally disabled or when medically necessary
- Early Start/Early Intervention. Early Start/Early Intervention is for children ages zero to three. If your PCP tells you that your child is at risk for developmental delays, your child may be eligible for the Early Start program. Developmental delays include difficulties in communicating, adjusting to different situations, following directions or relating to others. For more information about Early Start/Early Intervention or a referral to the Regional Center for Early Start/Early Intervention, talk to your doctor or to Anthem Blue Cross.
- Local Education Agency (LEA) assessment services are provided to students who qualify through the school system.
- Major organ transplants, except for renal or corneal transplants.
- Members with developmental disabilities. Developmental disabilities include difficulty learning and difficulty with motor skills. If your PCP tells you that you have a developmental disability, you may be eligible for services from the Regional Centers. For more information or for a referral to a Regional Center, talk to your PCP or call the Customer Care Center.
- Prayer or spiritual healing
- State laboratory services under the state Serum Alpha-fetoprotein Testing Program
- Home- and Community-Based Services Waiver Program provides services beyond those that are covered by Medi-Cal. These services allow individuals to remain in a community setting rather than be admitted to a long-term care facility.
Utilization Management

Our Utilization Management (UM) department:

- Makes decisions based only on appropriateness of care and service and existence of coverage
- Does not specifically reward practitioners or other individuals for issuing denials of coverage
- Does not get financial incentives to encourage decisions that result in underutilization

If we call you, our representative will tell you his or her name and title and let you know he or she is from Anthem Blue Cross so you know who you are talking to.

If you have questions or want information about the UM process and how we authorize care, you can call us toll free at 1-888-831-2246 (TTY 1-888-757-6034), Monday through Friday from 8 a.m. to 5 p.m. Pacific time. You can call us after hours or on the weekends. Leave a message with our secure answering service and we’ll call you back the next business day. We can also help you in your language.

Services you cannot get through Medi-Cal or Anthem Blue Cross

Some services are not covered by Anthem Blue Cross or Medi-Cal:

- Services not allowed by state and/or federal law
- Routine circumcision, unless medically necessary
- Cosmetic surgery (surgery performed to alter or reshape normal structures of the body in order to improve your appearance)
- Custodial care. Some custodial care may be covered under regular (fee-for-service) Medi-Cal. For more information about custodial care covered under regular Medi-Cal, call DPSS. You can find DPSS’ phone number under the Important Phone Numbers section of this handbook.
- Experimental and investigational services. You can learn more about this in “IMRs for Experimental and Investigational Therapies (IMR-EIT)” under the Complaints: What should I do if I am unhappy? section of this handbook.
- Infertility (diagnosis and treatment)
- Immunizations (shots) for sports, work or travel
- Nonmedical equipment
- Personal comfort items such as phones, television and guest tray when in the hospital
- Treatment for alcohol use disorders. If found to meet criteria for alcohol use disorder, the member will be referred to the alcohol and drug program in the county in which he/she lives for further evaluation and treatment
- Mental health services for relational problems are not covered. This includes counseling for couples or families for conditions listed as relational problems as defined by the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text revision (DSM IV)

If you have questions about what is covered or not covered, please call the Customer Care Center.

Specialty mental health services for severe mental illness may be needed for services beyond your PCP’s training and practice and the outpatient mental health services covered by Anthem Blue Cross. These services are provided through the Los Angeles County Department of Mental Health (LACDMH). You can receive services from LACDMH with or without a referral from your doctor. LACDMH can be reached toll free at 1-800-854-7771 (TTY 1-562-651-2549). No-cost interpreting services, including American Sign Language, are available to assist you with your mental health services.
Anthem Blue Cross will coordinate and cover laboratory, radiological and radioisotope services needed for the diagnosis, treatment and monitoring of a mental health condition. Anthem Blue Cross or regular (fee-for-service) Medi-Cal cover mental health drugs listed on the formulary and prescribed by your PCP or by a licensed mental health provider authorized to prescribe drugs. If medically necessary, you can also get a mental health drug not listed on the formulary. Go to a network pharmacy to fill your prescription. You can learn more about this in the Pharmacy benefits: How do I get prescription drugs? section of this handbook.
Pharmacy benefits: How do I get prescription drugs?
What is a pharmacy? A pharmacy is a store where you get your prescription medications filled.

Anthem Blue Cross works with pharmacies in many neighborhoods. You must get your prescription medications (drugs) from a pharmacy in Anthem Blue Cross’ network. A pharmacy list is in the provider directory provided to you with this handbook or you can call the Customer Care Center for pharmacies in your neighborhood. You can also call the 24/7 NurseLine for answers to questions about medication.

How to get a prescription filled
- Choose a pharmacy that works with Anthem Blue Cross.
- Bring your prescription to the pharmacy.
- Show the pharmacy your current Anthem Blue Cross ID card.
- Make sure you give the pharmacy your current address and phone number.
- Make sure your pharmacy knows about all medications you are taking and/or any allergies you have to any medicine.

If you have any questions about your prescription(s), make sure you ask the pharmacist.

You should not be asked to pay for covered prescription drugs. Call the Customer Care Center if a pharmacy asks you to pay.

Prescription refills
If you are refilling a prescription, go to a pharmacy listed in Anthem Blue Cross’ provider directory. You can also find pharmacies within Anthem Blue Cross’ network by visiting the pharmacy section of the Anthem Blue Cross website at www.anthem.com/ca/medi-cal.

You may be able to receive a 90-day supply of a maintenance medication excluding controlled substances. Maintenance medications are drugs that you need to take for a long time to treat a chronic medical condition, such as pills for high blood pressure or diabetes. Please ask your doctor to write a 30-day prescription supply, as well as a 90-day prescription supply for maintenance medication(s).

Pharmacy home program
Some members may be asked to join in our Pharmacy home program. This program helps members handle their controlled medications safely. You may be asked to join in this program if:
- You received prescriptions for controlled medications from three (3) or more providers.
- You filled prescriptions for controlled medications at three (3) or more pharmacies within the past 90-day period.

A Pharmacy home will fill all your prescriptions for controlled medications. In an emergency, you can get your prescriptions at another pharmacy.

If eligible, you will get a written notice asking you to join the program. If you join the Pharmacy home program, you will choose one pharmacy that works with us. If you do not choose a Pharmacy home, we’ll
choose the one closest to you. We’ll let your provider know when you join the program. You do not have to join the program if:

- You’re part of the foster care program; or
- You’re in hospice care or have cancer; or
- Being in the Pharmacy home program:
  - Prevents you from finding care; or
  - Causes an unnecessary health risk

You may not have to join for other reasons as well.

If you do not want to join the Pharmacy home program, you can file a grievance. To file a grievance, please see the Complaints: What should I do if I am unhappy? section in this handbook.

**What is a formulary?**

Anthem Blue Cross uses a list of approved drugs called a “formulary.” A committee of doctors and pharmacists reviews drugs to add or remove from the formulary every three months.

Drugs can be added to the formulary when they are all of the following:

- Approved by the Food and Drug Administration (FDA)
- Accepted to be safe and effective

Your PCP usually prescribes drugs from the Anthem Blue Cross formulary. Your PCP will only prescribe a drug based on your health status and if a medication is needed to improve your health.

Our formulary is on our website at www.anthem.com/ca/medi-cal. If you need a copy of the formulary in your language, large print, audio or alternate format, call the Customer Care Center.

**Brand name/Generic drugs**

A generic drug has the same active ingredient as the brand-name version of the drug. Generic drugs are approved by the Food and Drug Administration (FDA) and are usually more cost effective than brand-name drugs.

Generic medications are dispensed unless a documented medical reason prohibits the use of the generic version or a generic drug for a brand-name drug does not exist. Your doctor must contact Anthem Blue Cross to get an OK to dispense a brand-name drug if a generic is available.

**Drugs not on the formulary**

Sometimes, your doctor may need to prescribe a drug that is not on the formulary. Your doctor must contact Anthem Blue Cross and request prior authorization to get an OK.

To decide if this drug will be covered, Anthem Blue Cross may ask your provider for more information. Within 24 hours after getting the prior authorization request, Anthem Blue Cross will tell your provider and pharmacy if the drug is authorized. Anthem Blue Cross and/or your provider or pharmacy will then let you know if your drug is covered or not.

If the drug is approved, you can get the drug at a pharmacy that works with Anthem Blue Cross. If the drug is not approved, you have the right to appeal the decision or file a grievance. An “appeal” is when you want a
What drugs are covered?
You can get the following drugs and other items when they are prescribed by your doctor and are medically necessary:

- Prescription drugs listed on the Anthem Blue Cross formulary
- Nonprescription drugs or over-the-counter drugs (such as cough/cold syrups, cough drops or aspirin) listed on the Anthem Blue Cross formulary
- Formulary diabetic supplies:
  - Insulin
  - Insulin syringes
  - Glucose test strips
  - Lancets and lancet puncture devices
  - Pen delivery systems
  - Blood glucose monitors including monitors for the visually impaired
  - Ketone urine testing strips
- FDA-approved birth control devices, birth control pills, condoms and contraceptive jellies on the Anthem Blue Cross formulary
- Emergency contraception
- EpiPens, peak flow meters and spacers

What drugs are not covered?
- Drugs from a non-network pharmacy, except drugs needed because of an emergency
- Nonformulary drugs, except with an OK from Anthem Blue Cross by a prior authorization
- Drugs that are experimental or investigational in nature, except in certain cases of terminal illness. If you have been denied an experimental or investigational drug, you have the right to request an Independent Medical Review (IMR). You can learn more about this in the Complaints: What should I do if I am unhappy? section of this handbook
- Cosmetic drugs, except as prescribed for medically necessary conditions
- Nonformulary dietary or nutritional products, except when medically necessary or for the treatment of Phenylketonuria
- Any injectable drug that is not medically necessary and not prescribed by a doctor
- Appetite suppressants, except as medically necessary for morbid obesity
- Replacement of lost or destroyed drugs no more than two times each calendar year (from January to December)
- Infertility drugs

Emergency contraception ("Plan B")
You may get emergency contraceptive drugs from:
- Your PCP
- A pharmacy with a prescription from your PCP if you are younger than 17 years of age
- A pharmacy without a prescription if you are 17 years of age or older
- A pharmacy not in Anthem Blue Cross’ network. If this is the case, you may be asked to pay for the service. Anthem Blue Cross will reimburse you for this cost.
• A local family planning clinic

Call the Customer Care Center for a list of pharmacies that provide emergency contraceptive drugs.

**Compound Drugs**

Compound drugs are prescriptions that are mixed, combined, or altered to created medication tailored to the needs of an individual patient. Compounds can be covered when:

- a commercial formulation of medication is not available and
- all active ingredients are FDA-approved and
- all active ingredients require a prescription to dispense and
- the compound drug is not essentially the same as an FDA-approved product marketed by a drug manufacturer

Compounds are not covered when:

- a commercial formulation is available or
- active ingredients are not FDA-approved or
- active ingredients are not CMS Rebatable (The manufacturer has not signed rebate agreements with the Centers for Medicare & Medicaid Services.) or
- the compound includes proprietary vehicles, bases, and/or other pharmaceutical adjuvants

**How do you get medications during an emergency, after hours and holidays?**

Anthem Blue Cross members have access to “24-Hour” pharmacies that work with Anthem Blue Cross and are open 24 hours, 7 days a week.

You can find a “24-Hour” pharmacy closest to you by visiting our website at www.anthem.com/ca/medi-cal.

Pharmacies that work with Anthem Blue Cross can fill your medications any time and during an emergency. During an emergency, your pharmacist is also authorized to dispense a three-day or 72-hour supply of medication to avoid interruption of your current prescribed drug therapy.

**Medicare Part D: Prescription drug coverage for beneficiaries who get both Medicare and Medi-Cal**

Medicare administers a federal prescription drug program called Medicare Part D. If you are a Medi-Cal beneficiary with Medicare, you will get most of your prescription drugs from Medicare. There are some prescription drugs that are not covered by Medicare, but are covered by Medi-Cal, that you can get through Medi-Cal.

However, if you have Medi-Cal with Anthem Blue Cross and Medicare Part D coverage with another health plan, your pharmacy will not be able to fill your Medicare Part D prescriptions with your Anthem Blue Cross Medi-Cal coverage. Please contact your Medicare Part D Plan.

Please call the Customer Care Center for more information. To find out more about Medicare Part D and to choose a Medicare Prescription Drug Plan, call Medicare at 1-800-633-4227 (TTY 711) or go online to www.medicare.gov.
Emergency and urgent care: How do I get care in an emergency?

There is a difference between needing care urgently and an emergency. Urgent care is when a condition, illness or injury is not life-threatening, but needs medical care right away. Many of Anthem Blue Cross’ doctors have urgent care hours in the evening and on weekends.

How to get urgent care

Call your PCP. You may speak to an operator who answers calls for your PCP’s office when closed. Ask to speak to your PCP or the doctor on call. Another doctor may answer your call if your PCP is not available. A doctor is available by phone 24 hours a day, (seven) 7 days a week, and also on weekends and holidays.

Tell them about your condition and follow their instructions.

You may also call the 24/7 NurseLine, 24 hours a day, seven days a week.

You may receive same-day urgent care services. It should not take longer than 48 hours from the time you call to request an appointment to get urgent care services from your PCP. If you are outside of Los Angeles County, you do not need to call your PCP or get prior authorization before getting urgent care services. But, be sure to let your PCP know about the care you received because you may need follow-up care.

What is emergency care?

Emergency services are covered anywhere in the United States, Mexico and Canada, 24 hours a day, seven days a week. Emergency care is a service a member reasonably believes is necessary to stop or relieve:

- Serious illnesses or symptoms
- Injuries or conditions requiring immediate diagnosis and treatment

Emergency services and care include:

- Ambulance
- Medical screening
- Examination and evaluation by a doctor or other medical personnel

Emergency services include services for both physical and psychiatric emergency conditions and, in the case of a pregnant woman, services for conditions that would place her or her unborn child in serious jeopardy, as well as active labor.

Examples of emergencies include but are not limited to:

- Having trouble breathing
- Seizures (convulsions)
- Lots of bleeding
- Unconsciousness/blackouts (when you cannot wake up)
- Lots of pain (including chest pain)
- Swallowing of poison or medicine overdose
- Active labor
• Broken bones
• Head injury
• Eye injury
• Having thoughts of suicide or homicide

Examples of psychiatric emergency medical conditions include but are not limited to:
• Thoughts or actions about hurting yourself or someone else
• Unable to care for yourself, such as being unable to feed, shelter or dress yourself due to a mental disorder

If you think you have a health emergency, call 911. You are not required to call your doctor before you go to the emergency room. Do not use the emergency room for routine (regular) health care.

What to do in an emergency
Call 911 or go to the nearest emergency room if you have an emergency. Emergency care is covered at all times anywhere in the United States, Mexico and Canada.

Outside of Los Angeles County?
If you have an emergency when you are not in Los Angeles County, you can get emergency services at the nearest emergency facility. Emergency services do not require a referral or OK from your PCP.

If you are admitted to a hospital not in Anthem Blue Cross’ network or to a hospital your PCP or other provider does not work at, Anthem Blue Cross has the right to move you to a network hospital as soon as it is medically safe.

You may need hospital care after an emergency to stabilize your condition. This is called post-stabilization care. If you do, the hospital will call the Customer Care Center to ask for an OK. The hospital may ask you for your health plan’s name and phone number. Show the hospital your Anthem Blue Cross ID card. If you do not have your ID card, tell them to call the Customer Care Center.

Your PCP must provide follow-up care when you leave the hospital.

What to do after an emergency
• Call the Customer Care Center within 24 hours of receiving emergency care or as soon as you can.
• Follow the instructions of the emergency room doctor.
• Call your PCP to make an appointment for follow-up care.
• In cases of psychiatric emergencies, follow up with a psychiatric provider to make an appointment for follow-up care.

How to get emergency transportation
Call 911 if you have an emergency. Ambulances for emergencies are paid for by Anthem Blue Cross as long as you had a reasonable belief that an emergency condition existed at the time of the service.

Not sure you have an emergency?
If you are not sure, call your PCP, or Nurse Advice Line, and do what they tell you to do. Nonemergency
problems may include, but are not limited to the following:

- Sore throats
- Fever
- Minor lacerations.

Do not call 911 for nonemergency problems. Call your PCP if you believe you or someone may be experiencing a non-life-threatening psychiatric emergency. You can also call L.A. County’s Psychiatric Mobile Response Teams (PMRT) at 1-800-854-7771 (TTY 1-562-651-2549).

**Not sure what kind of care you need?**

Sometimes it is difficult to know what kind of care you need, so we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern and instruct you on self-care at home if appropriate.
- They can advise you about whether you should get medical care and how and where to get care. For example, if you are not sure whether your condition is an emergency medical condition, they can help you decide whether you need emergency care or urgent care, and how and where to get that care.
- They can tell you what to do if you need care and your PCP’s office is closed.
- You can reach one of these licensed health care professionals by calling Anthem Blue Cross’ 24/7 NurseLine. When you call, a trained support person may ask you questions to help determine how to direct your call.
Help in your language and for people with disabilities: How can I get help?

Written information in your language and format
You have the right to receive written member communication from Anthem Blue Cross in any of the following languages: Arabic, Armenian, Burmese, Chinese, Farsi, French, French Creole, German, Greek, Gujarati, Hebrew, Hindi, Hmong, Italian, Japanese, Khmer, Korean, Laotian, Polish, Portuguese, Russian, Serbian, Spanish, Tagalog, Thai, Urdu, Vietnamese, or Yiddish. You can also request to receive written member communication in large print, audio or another format.

No-cost interpreting services
You have the right to no-cost interpreting services when getting health care services.

Anthem Blue Cross offers no-cost interpreting services in your language, including American Sign Language. These services are available 24 hours a day, seven days a week.

It is important to use a professional interpreter at your doctor’s appointments to help you communicate with your doctor so that you can understand your health and how to take care of yourself. The professional interpreter is trained and knows medical words and will interpret everything that is said between you and your doctor correctly and completely. The interpreter keeps your conversation with your doctor confidential and private. You should not use friends or family, especially children, to interpret for you.

Call the Customer Care Center if you need interpreting services. We can assist you in your language over the phone and make sure that you have an interpreter for your next appointment. To request an interpreter:
1. Make your appointment with your doctor
2. Call the Customer Care Center at least 10 business days before your appointment with the following information:
   - Your name
   - Your member ID number
   - Date and time of your appointment
   - Doctor’s name
   - Doctor’s address and phone number

If your appointment with your doctor is changed or canceled, call the Customer Care Center as soon as possible.

TTY/TDD services
Deaf and hard of hearing members can call the Customer Care Center at 711 using a TTY/TDD device. This number will put you in contact with the California Relay Service (CRS). Trained operators at CRS will help you communicate with Anthem Blue Cross or your doctor.

Access information for people with disabilities
Many doctors’ offices and clinics have accommodations that make medical visits easier for people with disabilities such as accessible parking spaces, ramps, large exam rooms, and wheelchair-friendly scales. You can find doctors with such accommodations in the Provider Directory. The Customer Care Center can also help you locate a doctor who can meet your special needs.
A doctor’s office, clinic or hospital cannot deny you services because you have disabilities. Call Anthem Blue Cross right away if you cannot get the services you need or if services you need are difficult to get.

**Remember:** Tell your doctor’s office if you may require additional time during your visit because you need extra help.

**Complaints**
You can file a complaint if:
- You feel that you were denied services because of a disability or you do not speak English
- You cannot get an interpreter
- You have a complaint about the interpreter
- You cannot get information in your language
- Your cultural needs are not met

You can learn more about how to file a complaint in the **Complaints: What should I do if I am unhappy?** section of this handbook.
Complaints: What should I do if I am unhappy?
If you are unhappy or have questions or problems with your service or care, you have the option of letting your PCP know. Your PCP will be able to help you or answer your questions.

At any time, you or your Member Representative can file a grievance (complaint, concern or expression of dissatisfaction) with Anthem Blue Cross. A Member Representative is a person or persons appointed by the member, either on the phone or by written statement. A written statement is a statement to represent you in the State of California as a health care proxy, trustee named in a durable power of attorney or court-appointed guardian. This is also known as a Personal Representative. A Member’s Representative can be a spouse, relative, friend, attorney, advocate, doctor, practitioner or someone designated as a representative by the member. There are several ways a person can be named a Member’s Representative. Examples include Durable Power of Attorney, an Executor/Administrator of Estate or a legal/court-appointed guardian.

Anthem Blue Cross cannot take away your health care benefits or do anything to hurt you in any way if you file a grievance or use any of your privacy rights in this handbook.

What is a grievance?
A grievance is an expression of dissatisfaction or a complaint by a member. The grievance can be in writing or made verbally. You have the right to file a grievance.

You must file your grievance within 180 calendar days from the day you became unhappy with the service or care given to you by your PCP, specialist, medical group, hospital, pharmacy or Anthem Blue Cross.

How to file a grievance
If you wish to file a grievance or an appeal:
- Write, visit or call the Customer Care Center at:
  P.O. Box 9054
  Oxnard, CA 93031-9054
  1-888-285-7801

If you wish to file a grievance in writing, the Customer Care Center will be glad to provide you a grievance form.

You can also file a grievance online through Anthem Blue Cross’ website at www.anthem.com/ca/medi-cal.

You can ask your physician’s office for the information on how to file a grievance.

Anthem Blue Cross can help you fill out the grievance form over the phone or in person. If you need interpreter services to help you file your grievance, we will work with you to make sure we can communicate with you in a language you understand.

Call the Customer Care Center to get a grievance form in your language or another format. For members with hearing or speech loss, you may call the TTY/TDD telephone number for Member Services at 711.

Grievances for Medi-Cal eligibility are not processed by Anthem Blue Cross. To file a grievance about Medi-Cal eligibility, call the Department of Public Social Services (DPSS). You can find DPSS’ phone number
under the **Important Phone Numbers** section of this handbook. If you need assistance, the Customer Care Center will be able to help you locate the number.

**Confirmation and resolution of your grievance**

Within five (5) calendar days of getting your grievance, Anthem Blue Cross will send you a letter to let you know that we have your grievance and are working on it. Then, within 30 calendar days of getting your grievance, Anthem Blue Cross will send you a letter explaining how the grievance was resolved. The Grievance Department may contact you during the time of the investigation. You may also file a grievance with the Department of Managed Health Care (DMHC) if you do not hear from Anthem Blue Cross within 30 calendar days from the date you filed your grievance or if you are unhappy with the resolution of your grievance. See **Contacting the California Department of Managed Health Care (DMHC) to file a grievance or request an Independent Medical Review (IMR)** in this section.

**Please note:** You have the right to file an expedited grievance with the Department of Managed Health Care (DMHC) without filing an appeal with Anthem Blue Cross. For information on how to file an expedited grievance with the DMHC, see **Contacting the California Department of Managed Health Care (DMHC) to file a grievance or request an IMR** in this section.

**How to file a member appeal**

If you have been denied services by your doctor and disagree with the decision, you can file an appeal. When you have been denied services, you will receive a written notice of the denial. This is known as a Notice of Action. The Notice of Action may be a modification, or an adjustment of the request for services.

**What is a Notice of Action?**

A Notice of Action is a formal letter from Anthem Blue Cross, your medical group or your PCP telling you that a medical service has been denied. When you have been denied services, you will receive a written Notice of Action telling you why the service was denied and your appeal rights.

**What is an appeal?**

If you think we have made a mistake in denying your medical service or you do not agree with the decision, you can ask for an appeal. If you ask for an appeal, it means you are asking us to change the decision we made. An appeal is a formal request by a member, the member’s representative or the member’s doctor to review a denial of medical services.

You have 90 calendar days from the date on the Notice of Action to file an appeal with Anthem Blue Cross.

**An appeal is different from a grievance**

The main differences between an appeal and a grievance are:

**With an appeal:**
- You have been denied a medical service and you are unhappy with the decision.
- You received a letter called a Notice of Action letting you know that your services have been denied.
- You received a Notice of Action letter from Anthem Blue Cross or a medical group. You have 90 calendar days from the date on the letter to file an appeal with Anthem Blue Cross.
With a grievance:

- You are unhappy or dissatisfied with the service or care given to you by your doctor, specialist, medical group, hospital, pharmacy or Anthem Blue Cross.
- You did not get a Notice of Action letter because there has not been a denial of medical services.
- You have up to 180 calendar days from the day you became unhappy to file a grievance with Anthem Blue Cross.

If you receive a Notice of Action (NOA) from Anthem Blue Cross, you have three (3) options on how to file an appeal if you are unhappy with the decision:

- You have 90 calendar days from the date on the Notice of Action to file an appeal with Anthem Blue Cross. You may file the appeal in person, in writing, online, by fax, or via telephone, as listed above. We will send you a letter within five (5) calendar days to let you know that we have received your appeal. Then within 30 days from the day your appeal was received, we will let you know how your appeal was resolved.
- You may request a State Hearing regarding your Notice of Action from the Department of Social Services (DSS) within 90 calendar days from the date on the Notice of Action. Please refer to State Hearing in this section.
- You may request an Independent Medical Review (IMR) regarding your Notice of Action from the Department of Managed Health Care (DMHC). Please refer to Independent Medical Review in this section for help in requesting an IMR.

You can also file a grievance regarding the medical services related to the Notice of Action.

Please note that you may ask for a State Hearing at the same time you are filing your appeal to a Notice of Action. Filing a grievance, or appeal, or requesting a State Hearing does not affect your medical benefits. If you file a grievance, or appeal, or request a Fair Hearing, you can continue medical services while the grievance and/or appeal is being resolved. To find out more about continuing a medical service, call the Customer Care Center.

**Expedited review for urgent cases**

If you receive a Notice of Action (NOA) and your case is urgent, you can request an “expedited” (or quick) review of your case. Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious decline of your health

Anthem Blue Cross physicians will review the case to determine the urgency of the matter. If the matter is expedited (urgent), then the matter will be resolved within three calendar days. In urgent cases, you may file your appeal to Anthem Blue Cross either orally (via telephone or in person) or in writing. You can present evidence to support your appeal; however, the time available to present this evidence is limited to less than three calendar days. A decision will be made by Anthem Blue Cross within three calendar days from the day your appeal was received.

You also have the right to request an expedited State Hearing, along with filing an appeal with Anthem Blue Cross. For more information about State Hearings, go to State Hearing in this section.

You have the right to file an expedited grievance with the Department of Managed Health Care (DMHC) without filing an appeal with Anthem Blue Cross. For information on how to file an expedited grievance with
the DMHC, go to Contacting the California Department of Managed Health Care (DMHC) to file a grievance or request an IMR in this section.

If you do not agree with Anthem Blue Cross’ decision on an appeal
If you do not agree with the decision made on your appeal, if you prefer, you can request a State Hearing and file a grievance with the California Department of Managed Health Care (DMHC). You may also file a grievance with the DMHC if you do not hear from Anthem Blue Cross within three calendar days from the date you filed your urgent appeal. You may also request an Independent Medical Review (IMR) with the DMHC. For more information about State Hearings, go to State Hearing in this section. For information on how to file a grievance with the DMHC, go to Contacting the California Department of Managed Health Care (DMHC) to file a grievance or request an IMR in this section. For information on how to request an IMR, go to Independent Medical Review in this section of this handbook.

Independent Medical Review (IMR)
You can request an Independent Medical Review (IMR) from DMHC. You have up to six months from the date you get a Notice of Action from Anthem Blue Cross to file an IMR. A Notice of Action lets you know about an action by Anthem Blue Cross to delay, deny, modify or terminate a health care service or benefit. You will receive information on how to file an IMR with your notice. You may reach DMHC toll free at 1-888-HMO-2219 or 1-888-466-2219.

You can still request a State Hearing if you request an IMR. However, you will not be able to use the IMR process if you have requested a State Hearing. Go to State Hearing in this section to find out how to file a grievance.

There are no fees for an IMR. You have the right to provide information to support your request for an IMR. After the IMR application is submitted, a decision not to take part in the IMR process can cause you to lose certain legal rights to pursue legal action against the health plan.

When to file an Independent Medical Review
You may file an IMR if you meet the following requirements:

- Your PCP says you need a health care service because it is medically necessary, but it was denied; or
- You received urgent or emergency services determined to be necessary, but they were denied; or
- You have seen a network doctor for the diagnosis or treatment of the medical condition, even if the health care services were not recommended
- The disputed health care service is denied, changed or delayed by Anthem Blue Cross based in whole or in part on a decision that the health care service is not medically necessary; and
- You have filed a grievance with Anthem Blue Cross and the health care service is still denied, changed, delayed or the grievance remains unresolved after 30 calendar days

You must first go through the Anthem Blue Cross grievance process, before applying for an IMR. In special cases, the DMHC cannot require you to follow the Anthem Blue Cross grievance process before filing an IMR. In urgent circumstances or cases of emergency, you are not required to participate in the Anthem Blue Cross expedited grievance process for more than three (3) days before filing an IMR.

The dispute will be submitted to a DMHC medical specialist if it is eligible for an IMR. The specialist will make an independent decision on whether or not the care is medically necessary. You will receive a copy of the IMR decision from DMHC. If it is decided that the service is medically necessary, Anthem Blue Cross will
provide the health care service.

Nonurgent IMR cases
For nonurgent cases, the IMR decision must be made within 30 calendar days. The 30-calendar-day period starts when your application and all documents are received by DMHC.

Urgent IMR cases
If your grievance is urgent and requires fast review, you can bring it to DMHC’s attention right away. You will not be required to participate in the health plan grievance process.

For urgent cases, the IMR decision must be made within three calendar days from the time your information is received.

IMRs for experimental and investigational therapies (IMR-EIT)
You can request an IMR-EIT through the DMHC when a medical service, drug or equipment is denied because it is experimental or investigational in nature.

Anthem Blue Cross will notify you in writing that you can request an IMR-EIT within five (5) days of the decision to deny coverage. You have up to six (6) months from the date of denial to file an IMR-EIT. You can give information to the IMR-EIT panel. The IMR-EIT panel will give you a written decision within 30 calendar days from when your request was received. If your doctor thinks that the proposed therapy will be less effective if delayed, the decision will be made within seven (7) days of the request for an expedited (or quick) review. In urgent cases, the IMR-EIT panel will give you a decision within three (3) business days from the time your information is received.

You can file an IMR-EIT if you meet the following requirements:
- You have a very serious condition that is life-threatening or debilitating (for example, terminal cancer).
- Your PCP must certify that:
  - The standard treatments were not or will not be effective or
  - The standard treatments were not medically appropriate or
  - The proposed treatment will be the most effective
- Your PCP certifies in writing that:
  - A drug, device, procedure or other therapy is likely to work better than the standard treatment.
  - Based on two medical and scientific documents, the recommended treatment is likely to work better than the standard treatment.
- You have been denied a drug, equipment, procedure or other therapy recommended or requested by your PCP.
- The treatment would normally be covered as a benefit, but Anthem Blue Cross has determined that it is experimental or investigational in nature.

To find out more, get help with the IMR or IMR-EIT process or ask for an application form, please call the Customer Care Center.

You do not need to participate in Anthem Blue Cross’ grievance process before asking for an IMR of a decision to deny coverage on the basis that the treatment is experimental or investigational in nature.
Contacting the California Department of Managed Health Care (DMHC) to file a grievance or request an IMR

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first call the Customer Care Center and use your health plan’s grievance process before contacting DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR).

If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services.

The department also has a toll-free telephone number (1-888-HMO-2219) and a TTY/TDD line (1-877-688-9891) for the hearing and speech-impaired. The department’s website, (www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

State Hearing

A State Hearing is another way you can file a grievance or appeal. You can present your case directly to the State of California. All Anthem Blue Cross members have the right to ask for a State Hearing at any time within 90 days from the Notice of Action or 180 days of the incident. You can still request a State Hearing if you request an Independent Medical Review (IMR). However, you will not be able to use the IMR process if you have requested a State Hearing. Go to Independent Medical Review in this section to find out more.

During the State Hearing process, Anthem Blue Cross will continue to authorize and pay for the services under question while the hearing is pending. If a decision is later made to deny, limit, or delay services, Anthem Blue Cross will still pay for the disputed services if you received the services while the hearing was pending. You will not be held responsible for the cost of the services provided.

You can ask for a State Hearing by calling toll free 1-800-952-5253 (English and Spanish), or by writing to:
California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 09-17-37
Sacramento, CA 94244-2430

For TTY/TDD services, call 1-800-952-8349.

 Expedited State Hearing

In cases of health services denials, you or your provider can ask for a faster decision through an expedited State Hearing if your life, health or ability to attain, maintain or regain maximum function could be in serious danger by going through a standard State Hearing. An emancipated minor, a parent on behalf of his/her minor child, and a duly-appointed guardian or conservator of a member can also request an expedited State Hearing.
Requests for expedited State Hearings should be directed to:
Expedited Hearings Unit
California Department of Social Services State Hearings Division
744 P Street, MS 19-65
Sacramento, CA 95814
Phone: 1-800-952-5253
Fax: 1-916-229-4267

You can also call the DPSS Los Angeles County office toll free at 1-866-613-3777. If you do not speak English, please stay on the line and ask for the language you speak. DPSS has staff members who speak Armenian, Chinese, Russian, Spanish, Tagalog and Vietnamese. If DPSS does not have bilingual staff who speak your language, they will provide you with interpreting services at no cost to you. You can also write to:
Department of Public Social Services (DPSS) State Hearings Section
P.O. Box 10280
Glendale, CA 91209

Office of the Ombudsman
You can call the Medi-Cal Managed Care Office of the Ombudsman of the California Department of Health Care Services (DHCS) for help with grievances. The Office of the Ombudsman was created to help Medi-Cal beneficiaries fully use their rights and responsibilities as members of a managed care plan. To find out more, call toll free 1-888-452-8609 (TTY 1-800-896-2512).

Voluntary mediation
You can ask for mediation to resolve a grievance but Anthem Blue Cross can decline your request. If we approve your request, an independent third person will resolve your grievance. This person will not be related to Anthem Blue Cross. However, you and Anthem Blue Cross must agree to use the mediation process. You can still file a grievance with DMHC even if you use mediation. You do not need to participate in Anthem Blue Cross’ mediation process for any longer than 30 days prior to submitting a grievance to DMHC.
To request mediation, call the Customer Care Center.
Confidentiality: What are my privacy rights?
You have the right to keep your medical records confidential. That means that only people who need to see your records in order for you to get good health care will see them. You can request a copy of our Notice of Privacy Practices (NOPP). Just call the Customer Care Center. An NOPP is provided to you in this handbook. If you would like another copy of this information, call the Customer Care Center. The NOPP is also available on www.anthem.com/ca/medi-cal. The NOPP should be included in this handbook or with it as a separate document in order to meet HIPAA requirements.

Health information privacy
We want you to know the things that Anthem Blue Cross does to keep health information about you and your family private. For example, employees are not allowed to speak about your information in elevators or hallways. Employees must also protect any written or electronic documents containing your health information across the organization. Employees have access only to the amount of information needed to do their job. Anthem Blue Cross’ computer systems protect your electronic health information at all times by using various levels of password protection and software technology.

Anthem Blue Cross does not give out health information to anyone or any group that does not have a right to the information by law.

All Anthem Blue Cross staff with access to your health information are trained on privacy and information security laws. They also follow Anthem Blue Cross rules on how to take care of your health information so it stays private. They follow Anthem Blue Cross policies and procedures to protect conversations about you as well as written and electronic documents that contain protected health information about you. Employees even sign a note that promises they will keep all health information private.

Anthem Blue Cross needs information about you so that we can give you good health care services. We may get this information from you or any of these other sources:
- A parent, guardian or conservator
- Another health plan
- Your doctor
- Your application for the health care program
- Your health records
- The California Department of Health Care Services

Anthem Blue Cross does not have complete copies of your medical records.

The routine collection, use and disclosure of your protected health information and other kinds of private information may include:
- Name
- Gender
- Date of birth
- Language you speak
- Race/ethnicity
- Home address
- Home or work telephone number
Before Anthem Blue Cross gives your health information to someone else or another group, we need your approval in writing. However, there are times when we do not have to get your approval in writing. For more information on how Anthem Blue Cross may use or share your protected health information and when your OK is needed, please read the Notice of Privacy Practices (NOPP) provided to you in this handbook. If you have any questions, would like a printed copy of the NOPP mailed to you, would like to pick up a paper copy of the NOPP or would like to know more about the privacy, information security and confidentiality of your health information, please call the Privacy & Information Security Officer at 1-757-473-2737, ext. 33165.

If you believe that your privacy has not been protected, you have the right to complain. You can file a grievance (complaint) by contacting Member Services at, or you can contact the Department of Health Care Services (DHCS) at 1-916-445-4171 (TTY 711) or the U.S. Office for Civil Rights at 1-866-627-7748 (TTY 1-866-788-4989. These phone numbers are available to you 24 hours a day, seven (7) days a week. All calls are confidential. All calls are free.

**Protect yourself from identity theft**

Here are some steps you can take to help prevent your personal information from being stolen, also known as identity theft:

- Protect your member ID card like you protect your bank or credit cards.
- Take your ID card to your doctor’s appointment. Avoid speaking about your membership information, personal facts or saying your Social Security number aloud or to other people.
- Do not give out your personal information unless it is asked for by your doctor, clinic, hospital, other medical staff or health plan.
Fraud, waste and abuse: How do I identify it and report it

What is fraud?
Fraud means intentionally deceiving or misrepresenting information knowing that this could result in an unauthorized benefit to yourself or another. Examples include using someone else’s medical benefits for your health care services, using someone else’s Social Security number to qualify for government assistance, or a doctor intentionally billing for services that did not occur. If you commit fraud, you may lose your Medi-Cal coverage.

What is waste?
Waste is the overuse of services or careless practices that result in throwing away or the spending of health care or government resources in an unwise and wrong manner. Examples of waste include:
- Prescribing more medication than is medically necessary
- Providing more health care services than are medically necessary

What is abuse?
Abuse is an action that may result in unnecessary cost to government programs such as Medi-Cal. Abuse may also result in improper payment to doctors or members. Examples of abuse include:
- Requesting and obtaining medications or medical equipment you do not need for yourself
- Excessive use of emergency room (ER) for nonemergency or routine care

How to report fraud, waste and abuse
If you suspect someone of using your information or committing fraud, waste or abuse, please call the Customer Care Center at 1-888-285-7801 (TTY 711). This number is available 24 hours a day, seven days a week. You can also report it online at www.anthem.com/ca/medi-cal.

You can also call the Compliance Officer at 1-818-291-6942 (TTY 711), or you could call the California Department of Health Care Services Fraud & Abuse Hotline at 1-800-822-6222 (TTY 711) or contact the Department of Justice Office of the Attorney General Bureau of Medi-Cal Fraud & Elder Abuse at http://oag.ca.gov/consumers. Your call is free and confidential.

Why should you care about fraud, waste and abuse?
Everyone is hurt by fraud and abuse. Millions of dollars are paid to those not entitled to receive services or cash. That money could be spent to provide more care to people in need or more benefits to you. Do you know someone getting care that they are not entitled to receive? Do you suspect a doctor or lab of billing too much or billing for services not provided? If so, please call the Customer Care Center.

Preventing health care fraud
Here are a few helpful tips on how you can help prevent health care fraud:
- Do not give your ID card or ID card number to anyone except your doctor, clinic, hospital, health care provider or health plan.
- Do not let anyone borrow your ID card.
- Never loan your Social Security card to anyone.
• Never sign a blank insurance claim form.
• Beware of anyone who offers you free medical services in exchange for your ID card. You should never give away your ID card to anyone in exchange for free medical services. If it sounds too good to be true, it probably is. Be careful about accepting medical services in addition to Medi-Cal when you are told they will be free of charge.
• Report actions that do not seem right to you:
  o Did you get a bill or statement for services you did not receive?
  o Did a doctor or staff member ask you to pay for a service you feel is a covered benefit?
  o Were you or your child assigned to another doctor or group without your knowing or agreeing to it? If so, call the Customer Care Center.
Medi-Cal: How can I make sure I do not lose my coverage?

Keeping your Medi-Cal eligibility
To stay in Medi-Cal, you must be eligible for it. “Eligible” means that a person meets certain requirements to receive benefits from programs like Medi-Cal.

If you lose Medi-Cal eligibility, you will not be able to keep your Medi-Cal benefits with Anthem Blue Cross. Be sure to fill out and return any information requested before the due date on any letter or form. If you have any questions about your Medi-Cal eligibility, call your eligibility worker or the Department of Public Social Services (DPSS) toll free at 1-866-613-3777 (TTY 1-877-735-2929).

If you move, you must tell us!
Do not lose your Medi-Cal coverage if you move! DPSS must have your current address so they can send you mail to renew and stay eligible.

If you move but still live in Los Angeles County, please:
- Call your eligibility worker at DPSS right away at 1-866-613-3777; and
- Call the Customer Care Center. We need to know your new address and phone number.

If you move outside of Los Angeles County but still live in California, call your eligibility worker at DPSS right away. Your eligibility worker can help you find out what Medi-Cal services are available in your new community.

There are two types of Medi-Cal in Los Angeles County: “fee-for-service” and “managed care.” In Los Angeles County, most Medi-Cal members are in “managed care.”

Anthem Blue Cross is a managed care health plan.

“Managed care” is when your health care is managed and coordinated by a health plan and a PCP. This makes it easier for you to get the care you need. It is Anthem Blue Cross’ job to make sure you get the care you need. For example, if you need to see a specialist, it is your PCP’s and our job to find a specialist who will see you. In “fee-for-service” Medi-Cal, you are not in a health plan and must find doctors and other providers who will accept payment from Medi-Cal. No one manages or coordinates your care for you. No one helps you find doctors and providers who will accept payment from Medi-Cal.

This section explains why you are in managed care and the reasons why you can or cannot be enrolled in or disenrolled from a managed care health plan. To “enroll” means you become a member of a health plan. To “disenroll” means you leave a health plan and are no longer a member.

Mandatory Medi-Cal managed care members
The California Department of Health Care Services (DHCS) is in charge of Medi-Cal. DHCS says that in Los Angeles County, most Medi-Cal members must enroll in a health plan and be in managed care. Members who must enroll in a health plan are called “mandatory members.”

A mandatory member may not disenroll from Medi-Cal managed care. However, you may choose to change
health plans.

**Voluntary Medi-Cal managed care members**

In Los Angeles County, some people with Medi-Cal can choose to enroll in a health plan. Members who choose to enroll in a health plan are called “voluntary members.” A voluntary member can choose to leave his or her health plan. Voluntary members include:

- Children in foster care or the Adoption Assistance Program

To “disenroll” means you leave a health plan and are no longer a member. You can disenroll without cause at any time, subject to any restricted disenrollment period. To disenroll from Anthem Blue Cross, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077). Health Care Options enrolls or disenrolls Medi-Cal beneficiaries in or out of a Medi-Cal managed care health plan. They will send you a disenrollment form. Your membership will end on the last day of the month in which Health Care Options approves your request. Disenrollment takes 15 to 45 days. You must continue to receive services through Anthem Blue Cross until you are disenrolled from Anthem Blue Cross.

If you leave Anthem Blue Cross, you cannot stay enrolled with Anthem Blue Cross for your Medi-Cal coverage.

**Involuntary disenrollments**

You will lose managed care coverage with Anthem Blue Cross, but not necessarily your Medi-Cal benefits, if any of the following happens:

- You move out of Los Angeles County permanently.
- You require medical health care services not provided by Anthem Blue Cross (for example, some major organ transplants and chronic kidney dialysis).
- You have been approved and accepted as a candidate to a transplant center.
- You have other nongovernment or government-sponsored health coverage.
- You are in prison or jail.

If you are a mandatory or voluntary member, you can also be disenrolled from Anthem Blue Cross, even if you do not want to leave, if:

- You take part in any fraud having to do with services, benefits or facilities of the plan.
- Anthem Blue Cross is not able, in good cause, to give health care services to you. Anthem Blue Cross will use their best efforts to provide the needed services.
- If you show threatening behavior toward other members, providers, provider staff, or Anthem Blue Cross staff, Anthem Blue Cross may recommend that you be disenrolled from Anthem Blue Cross. Threatening behavior includes:
  - Making a credible threat of violence, considered as a knowing and willful statement or course of conduct that would place a reasonable person in fear for his or her safety, or the safety of others
  - Unlawful violence
  - Harassing surveillance, also known as “stalking,” which is willful, malicious, and repeated following of providers, provider staff, or Anthem Blue Cross staff
  - Threatening phone calls, letters, or other forms of threatening written or electronic communications directed at providers, provider staff, or Anthem Blue Cross staff
  - Unauthorized possession or inappropriate use of firearm, weapon, or any other dangerous device on provider or Anthem Blue Cross premises
Intentional destruction or threat of destruction of property owned, operated or controlled by providers, health plans or Anthem Blue Cross

Anthem Blue Cross will continue to provide you with covered services until the California Department of Health Care Services (DHCS) grants this request for disenrollment.

If you are disenrolled from Anthem Blue Cross because you have shown threatening behavior, you may file an appeal with the California Department of Managed Health Care (DMHC) if you think that your cancellation is because of your health status or need for services. This means you can ask DMHC to make sure we are allowed to disenroll you. You may also ask for a review from the California Department of Health Care Services (DHCS). You can learn more about this in the Complaints: What should I do if I am unhappy? section of this handbook. You can also call the Customer Care Center to find out more.

Expedited disenrollment
Anthem Blue Cross will process an expedited disenrollment if we are not able to provide you with medical services due to your condition or situation that is indicated in Anthem Blue Cross’ contract with the California Department of Health Care Services (DHCS). This may include a major organ transplant, foster care or adoption assistance programs or if you move out of Los Angeles County. We will submit a disenrollment request to DHCS for approval. When we receive the decision, we will notify you of the effective date of disenrollment. Your health care for the condition will be covered by regular Medi-Cal.

Transitional Medi-Cal
Transitional Medi-Cal is also called “Medi-Cal for working people.” You may be able to get transitional Medi-Cal if you stop getting Medi-Cal because:

- You started earning more money; or
- Your family started receiving more child or spousal support

For example, if you are the person in your household who earns the most money, you might get transitional Medi-Cal. This means you might get transitional Medi-Cal even if you are a caretaker relative.

Parents and caretaker relatives who get transitional Medi-Cal can get free Medi-Cal coverage for six to 24 months. If you stopped getting Medi-Cal, you should ask your eligibility worker if you qualify for transitional Medi-Cal. Call your eligibility worker at DPSS toll free at 1-866-613-3777 (TTY 1-877-735-2929). You can stay with Anthem Blue Cross if you are eligible for transitional Medi-Cal.
Getting involved: How do I participate?

Quality Improvement
We provide a comprehensive quality improvement program and always strive to make care and services better for you. We look at the care you get by reviewing:
- Claim data
- Member complaints
- Reports from outside agencies

We also look at whether we met the goals we set and decide how to do better in the future.

As part of this, we survey members and providers to learn how we can make our services better. If you want more information, including how we are doing, or have questions or concerns, please call the Customer Care Center. You can also visit us online at www.anthem.com/ca/medi-cal.

Policies
Many Anthem Blue Cross policies are decided by California Department of Health Services. Other policies are set by Anthem Blue Cross and members like you. There are several ways you can participate.

L.A. Care public policy committee
As an Anthem Blue Cross member, you can join the L.A. Care public policy committee. This committee discusses member and health plan issues. To find out more, please call the Customer Care Center.

Regional Community Advisory Committees (RCAC)
L.A. Care also has 11 L.A. Care Regional Community Advisory Committees (RCAC) in Los Angeles County. Their purpose is to let members give input to the Board of Governors that might affect policies, procedures, programs and practices. Because you are an Anthem Blue Cross member, you can join an RCAC and:
- Talk about health and health care service issues that affect Anthem Blue Cross members
- Advise the Anthem Blue Cross Board of Governors
- Educate and empower the community on health care issues

RCACs meet every other month. RCACs include Anthem Blue Cross members, community-based organizations that work with Anthem Blue Cross members, and health care providers. To find out more about RCACs, call the Anthem Blue Cross Community Outreach and Engagement Department toll free at 1-800-227-3238 (TTY 1-888-757-6034).

Board of Governors meetings
The Board of Governors decides policies for Anthem Blue Cross. Anyone can attend these meetings. The Board of Governors meets on the first Thursday of each month starting at 2 p.m. To find out more, call the Customer Care Center.

Communicating policy changes
As an Anthem Blue Cross member, you will get information on all policy changes that affect your health care. All important information will be included in your member newsletter or special mailings.
More important information: What else do I need to know?

How to request copies of policies and procedures
As a member of Anthem Blue Cross, you may request a copy of our clinical and administrative policies and procedures. These are the "business rules" that we use to make our day-to-day decisions and may help you understand the guidelines we use to manage your care.

If you would like a copy of our policies and procedures, you may request a copy by any of the methods listed below. Please tell us which topic you would like to learn more about and make sure to include the address where you would like us to send you the policies and procedures.

Write, visit, fax or call the Customer Care Center at:
  P.O. Box 9054
  Oxnard, CA 93031-9054
  1-888-285-7801

If you travel outside of Los Angeles County
As a member of Anthem Blue Cross, your service area is Los Angeles County. All locations outside of Los Angeles County are out of your service area.

Routine care is not covered out of the service area. However, emergency and urgent care services are covered outside of Los Angeles County.

How a provider gets paid
Health care providers can be paid in several ways by the health plan or medical group that they may have a contract with. Providers may receive:
- A fee for each service provided
- Capitation (a flat rate paid each month per member)
- Provider incentives or bonuses

Please call the Customer Care Center if you would like to know more about how your doctor is paid or about financial incentives or bonuses.

If you have other insurance
Please call the Customer Care Center to tell us about any health insurance you have other than Anthem Blue Cross so that we can send all bills to the correct place for payment. Generally, Medi-Cal is the “payor of last resort,” which means that Medi-Cal will cover and pay for Medi-Cal-covered services only after any other health insurance you have either denies coverage or your benefits under your other insurance have been exhausted.

If you have Medi-Cal and Medicare coverage
If you have both Medicare and Medi-Cal benefits, Medicare is your main coverage. You will still go to your Medicare doctors, specialists, hospitals and get most of your prescriptions from Medicare. Anthem Blue Cross will work with your Medicare doctor to provide you with Medi-Cal services you need.
This handbook explains your Medi-Cal benefits through Anthem Blue Cross. Anthem Blue Cross will take care of your copayments, medical services and supplies that are not covered by Medicare.

In order for Anthem Blue Cross to cover a service, the service must be:

- Not covered by Medicare; and
- Covered by Medi-Cal; and
- Medically needed

**Workers’ compensation**

Anthem Blue Cross will not pay for work-related injuries covered by Workers’ Compensation. Anthem Blue Cross will provide health care services you need while there are questions about an injury being work-related. Before Anthem Blue Cross will do this, you must agree to give Anthem Blue Cross all information and documents needed to recover costs for any services provided.

**Third party liability**

Anthem Blue Cross will provide covered services when an injury or illness is caused by a third party. Anthem Blue Cross may request the legal right to keep any payment or right to payment you may have received as a result of a third party injury or illness. Under California State Law, this is called “asserting a lien.” The amount of this lien may include:

- Reasonable and true costs paid for health care services given to you
- An additional amount as provided under California State Law

As a member, you also agree to help Anthem Blue Cross in recovering payments for services provided. This may require you to sign or provide documents needed to protect the rights of Anthem Blue Cross.

**Medi-Cal Estate Recovery Program**

The Medi-Cal program pays for medical care for some people whose savings and income are too low for them to be able to pay for their own care. The cost of a member’s medical care may have to be paid back to the Medi-Cal program after the member’s death. This is called the Medi-Cal Estate Recovery Program. After getting notice of the death of a member, the Department of Health Care Services (DHCS) will decide if the cost of the member’s medical care must be paid back. DHCS will never ask for more to be paid back than the value of the assets owned by the member at the time of his or her death.

To learn more about the Medi-Cal Estate Recovery Program, write or call DHCS:

California Department of Health Care Services (DHCS) Estate Recovery Section, MS 4720

P.O. Box 997425
Sacramento, CA 95899-7425
1-916-650-0490
1-916-650-6584 (fax)

**Disruption in services**

Anthem Blue Cross will use its best efforts to provide services in the event of a war, riot or other unusual event. If Anthem Blue Cross is not able to provide health services, we will send members to the nearest hospital for emergency services and pay for these services.
Organ donation
There is a need for organ donors in the United States. You can agree to donate your organs in the event of your death. The California Department of Motor Vehicles (DMV) will give you a donor card if you wish to become an organ or tissue donor and will also give you a donor sticker to place on your driver’s license or ID card. To find out more, call 1-800-777-0133 (voice) or 1-800-368-4327 (TTY/TDD).

What is an advance directive?
An advance directive is a signed legal document. It allows you to select a person to make your health care choices at a time when you cannot make them yourself (for example if you are in a coma). An advance directive must be signed when you are able to make your own decisions. Anthem Blue Cross will tell you about any changes to state law about advance directives as soon as possible but no later than 90 days after the date of change. Ask your doctor or call the Customer Care Center to find out more about advance directives.

New technology
Anthem Blue Cross follows changes and advances in health care by studying new treatments, medicines, procedures and devices. We call all of this “new technology.” We review and use scientific reports and information from the government and medical specialists to decide whether to cover the new technology. Members and providers may ask Anthem Blue Cross to review new technology.
Glossary of Terms
This glossary will help you understand words used in this Member handbook.

**Acute** is a word used for a serious and sudden condition that lasts a short time and is not chronic. Examples include a heart attack, pneumonia or appendicitis.

**Advance Directive** is a signed legal document that allows you to select a person to make your health care choices at a time when you cannot make them yourself. It expresses your decision about your end-of-life care ahead of time.

**Americans with Disabilities Act (ADA)** is a law that protects people with disabilities from not being treated fairly. The ADA law makes sure there are equal chances for people with disabilities in employment and state and local government services, including health care.

**Anti-rejection medications** are medications used to prevent your body from not accepting a new organ.

**Authorize/Authorization** is when a health plan approves treatment for covered health care services. Members may have to pay for nonapproved treatment. **Note:** Emergency services and out-of-area urgent care services do not require prior authorization.

**Benefits** are the health care services, supplies, drugs and equipment that are medically necessary and covered by Medi-Cal.

**California Children’s Services Program (CCS)** is the public health program that assures the delivery of specialized diagnostic, treatment and therapy services to financially and medically eligible children under the age of 21 who have CCS-eligible conditions.

**California Department of Health Care Services (DHCS)** is the state agency that is responsible for the Medi-Cal program.

**California Department of Managed Health Care (DMHC)** is the state agency responsible for regulating health care service plans.

**Cancer Clinical Trial** is a research study with cancer patients to find out if a new cancer treatment or drug is safe and treats a member’s type of cancer.

**Case Management** refers to doctors and nurses who make sure that you are getting the right health care services when you need them. This includes checkups, plans to make you better, getting you the right doctors, and coordinating care to meet your health care needs.

**Certified Nurse-Midwife** is a registered nurse who has experience in labor and delivery, and at least one year of hands-on training in midwifery. A certified nurse-midwife has completed an advanced course of study and is certified by the American College of Nurse-Midwives.

**Certified Nurse Practitioner** is a registered nurse who has completed an advanced training program in a medical specialty.
**Child Health and Disability Prevention (CHDP)** is for people under the age of 21 with a disability. CHDP is a preventive program that delivers periodic health assessment and services. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

**Chronic** is a word used for a condition that is long-term and ongoing, and is not acute. Examples include diabetes, asthma, allergies and hypertension.

**Clinic** is a facility that members can select as a primary care provider (PCP). It can be either a Federally Qualified Health Center (FQHC), Los Angeles County clinic, community clinic, rural health clinic, Native American Health Clinic or other primary care facility.

**Complain/Complaint** is an oral or written expression of dissatisfaction, including any complaint dispute request for reconsideration or appeal. A complaint is also known as a grievance.

**Consultation** is the rendering of an opinion, advice, or prescribing treatment by telephone and includes rendering of a decision regarding hospitalization or transfer by telephone or other means of communication.

**Diagnostic/Diagnosis** is when a doctor identifies a condition, illness or disease.

**Disability** is a physical or mental condition that substantially limits a person’s ability in at least one major life activity.

**Disenroll/Disenrollment** is when a member leaves a health plan.

**Disputed health care service** is a health care service eligible for coverage and payment under a plan that has been denied, modified or delayed based on the plan’s decision that the service was not medically necessary.

**Durable Medical Equipment** is medical equipment used in the course of treatment or home care, including items such as crutches, knee-braces or wheelchairs.

**Eligible/Eligibility** means that a person meets certain requirements to receive benefits from programs such as Medi-Cal, California Children’s Services (CCS) and Child Health and Disability Prevention Program (CHDP).

**Enroll/Enrollment** is when a member joins a health plan.

**Emergency Services** are covered anywhere in the United States, Mexico or Canada 24 hours a day, seven days a week. Emergency care is a service a member reasonably believes is necessary to stop or relieve serious illness or symptoms, injury or conditions requiring immediate diagnosis and treatment, including physical and psychiatric emergency conditions and active labor.

**Emergency Services and Urgent Care** means medical screening, examination, and evaluation by a physician or surgeon, or other licensed persons under the supervision of a physician and surgeon and includes a determination within the scope of that person's license if an emergency medical condition, psychiatric medical condition or active labor exists and, if it does, the care, treatment, and surgery necessary to relieve or eliminate the emergency medical condition.

**Exclusions** are any medical, surgical, hospital or other treatments for which the program offers no coverage.
**Expedited Review** is a complaint that must be resolved as quickly as possible if it involves an imminent or serious threat, including but not limited to, severe pain or the potential loss of life, limb or major bodily function. With an expedited review, the health plan will resolve the complaint as quickly as the medical condition requires and no later than within 72 hours.

**Experimental** or investigational in nature refers to new medical treatment that is still being tested but has not been proven to treat a condition.

**Family planning services** help people learn about and plan the number and spacing of children they want through the use of birth control.

**Federally Qualified Health Center (FQHC)** is a community-based health organization that provides comprehensive primary health, oral health, mental health and substance abuse services.

**Fee-For-Service Medi-Cal**, also known as regular Medi-Cal, is the component of the Medi-Cal Program that is paid directly by the state for services.

**Food and Drug Administration (FDA)** is the U.S. government agency that enforces the laws on the manufacturing, testing, and use of drugs and medical devices.

**Formulary** is a list of approved drugs that is generally accepted in the medical community as safe and effective.

**Grievance** is sometimes called a complaint. A grievance is the process used when a member is not happy with his or her health care. Grievances are about services or care received or not received.

**Health care services** prevent and treat disease, and keep people healthy. Examples include, but are not limited to, some of the following:
- Doctor services (includes one-on-one visits with a doctor and referrals)
- Emergency services (includes ambulance and out-of-area coverage)
- Home health services
- Hospital inpatient and outpatient services
- Laboratory services
- Pharmacy services
- Preventive health services
- Radiology services

**Health Maintenance Organization (HMO)** is an organization that, through a coordinated system of health care, provides or assures the delivery of an agreed-upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined, periodic fixed prepayment.

**Health Plan** means an individual or group plan that arranges for the provision, or pays the cost of, medical care.

**Hospice** is the care and services provided to people who have received a diagnosis for a terminal illness. These services are given in a home or facility to relieve pain and provide support.
**Hospital** provides inpatient and outpatient care from doctors or nurses.

**Human Immunodeficiency Virus** (HIV) is the virus that affects the immune system and causes the disease known as AIDS (acquired immunodeficiency syndrome).

**Independent Medical Review for Experimental and Investigational Therapies (IMR-EIT)** is a process by which expert independent medical professionals are selected to review a denial by the health plan for a medical service, drug or equipment because it is experimental or investigational in nature.

**Independent Physician Association (IPA)** is a company that organizes a group of doctors, specialists and other providers of health services to see members.

**Infertility** is when a person is not able to conceive and produce children after having unprotected sex on a regular basis for more than 12 months.

**Inpatient** is when a person receives medical treatment in a hospital or other health care facility with an overnight stay.

**Interpreter** is a person who expresses a message spoken or signed in one language into a second language and who abides by a code of professional ethics.

**Involuntary/Involuntarily** is when something is done without choice.

**Liable/Liability** is the responsibility of a party or person according to law.

**Life-threatening** is a disease, illness or condition that may put a person’s life in danger if it is not treated.

**Local Education Agency** is the school district or county office of education that will receive and disburse grant funds.

**Managed care** is a health care system in which the health care provider, in return for a fixed fee per year from a health plan, manages the care of the individual, including decisions about whether a specialist is required.

**Medi-Cal** is a California health coverage program for low-income families. This program is funded by state and federal dollars.

**Medi-Cal card**, also known as the Benefits Identification Card (BIC), is the plastic card issued by the state to Medi-Cal recipients. The BIC is used by providers to verify Medi-Cal eligibility.

**Mediation** is a process by which a neutral person tries to help individuals resolve a dispute. The results of the mediation are not binding.

**Medical group** is a group of PCPs, specialists, and other health care providers who work together.

**Medically necessary/Medical necessity** refers to all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to ease severe pain through the diagnosis or treatment of disease, illness or injury.
**Member** is a person who has joined a health plan.

**Member Handbook** is what you are reading right now. It has information about the benefits, services and terms offered by the health plan.

**Member Representative** is a person or persons appointed by the member, via written statement, to represent them in the State of California as a health care proxy, trustee named in a durable power of attorney or court-appointed guardian. Also known as Personal Representative(s), a Member Representative may be a spouse, relative, friend, advocate, your doctor, a practitioner or someone designated as a representative by the member under Durable Power of Attorney, or as an Executor/Administrator of Estate or as a legal/court-appointed guardian.

**Member Services Department** is the health plan’s department that helps members with questions and concerns.

**Mental or behavioral health services** are given for the diagnosis or treatment of a mental or emotional illness.

**Network** is a team of health care providers contracted with a health plan to provide services. The health care providers may be contracted directly with the health plan or through a medical group.

**Noncontracted provider** is a doctor or provider who is not under contract with the health plan to provide services to members.

**Nonformulary drug** is a drug that is not listed on the health plan’s formulary and requires an authorization from the health plan in order to be covered.

**Notice of Privacy Practices (NOPP)** informs the member how medical information may be used and distributed by the health plans.

**Nurse Advice Line** is a 24-hour telephone line supported by registered nurses who are available to help people with health questions or concerns.

**Occupational therapy** is used to improve and maintain a patient’s daily living skills when the patient has a disability or injury.

**Orthotic** is used to support, align, correct or improve the function of movable body parts.

**Outpatient** is when a person receives medical treatment in a hospital or other health care facility without an overnight stay.

**Out-of-area services** are emergency care or urgent care services provided outside of the health plan’s service area that could not be delayed until the member returned to the service area.

**Out-of-network providers** are doctors and providers not under contract, either directly or indirectly, with the health plan.

**Pediatric sub-acute services** are the health care services needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.
Pharmacy is a place to get prescribed drugs.

Phenylketonuria (PKU) is a rare disease. PKU can cause intellectual and developmental disabilities and other neurological problems if treatment is not started within the first few weeks of life.

Physical therapy uses exercise to improve and maintain a patient’s ability to function after an illness or injury.

Physician is a licensed medical doctor.

Prescription is a written order given by a licensed provider for drugs and equipment.

Preventive health care consists of health checkups or services given at certain times due to a person’s age, gender and medical history in order to keep that person well.

Primary care is a basic level of health care usually provided in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians and mid-level practitioners. This type of care emphasizes caring for the member’s general health needs as opposed to specialists focusing on specific needs.

Primary care provider (PCP) is a doctor or clinic that takes care of a member’s health care needs and works with the member to keep them healthy. The PCP will also make specialty referrals when medically necessary.

Prior authorization is a formal process requiring a health care provider to obtain advanced approval to provide specific services or procedures. Prior authorization is required for most services or care. However, for emergency or out-of-area urgent care services, prior authorization is not required.

Prosthesis is used to replace a missing part of the body.

Providers are contracted with a health plan to provide covered health care services. Examples include:
- Doctors
- Clinics
- Hospitals
- Skilled nursing facilities
- Sub-acute facilities
- Home health agencies
- Pharmacies
- Laboratories
- X-ray facilities
- Durable medical equipment suppliers

Provider directory is a list of providers contracted with a health plan.

Provider network is a group of doctors, specialists, pharmacies, hospitals and other health care providers that are contracted by and work with the health plan.

Referrals are when a doctor sends a member to another doctor, such as a specialist or providers of services including lab, X-ray, physical therapy and others.
**Service area** means the ZIP codes in Los Angeles County that the health plan, to which a member is assigned, serves.

**Skilled nursing facility** is a facility licensed to provide medical services for non-acute conditions.

**Specialist** is a physician or other health professional who has advanced education and training in a clinical area of practice and is accredited, certified, or recognized by a board of physicians or peer group, or an organization offering qualifying examinations (board certified) as having special expertise in that clinical area of practice.

**Specialty mental health services** are rehabilitative services that include mental health services, medication support services, day treatment intensives, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services such as:

- Psychiatric inpatient hospital services
- Targeted case management
- Psychiatric services
- Psychologist services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services

**Speech therapy** is used to treat speech problems.

**Standing referral** is a referral by a doctor for more than one visit by a specialist.

**Sub-acute care** is a level of care needed by a patient who does not require hospital acute care, but who requires more intensive skilled nursing care than is provided to the majority of patients in a skilled nursing facility.

**Triage or screening** is the evaluation of a member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the member's need for care.

**Triage or screening waiting time** is the time waiting to speak by telephone with a doctor or nurse who is trained to screen a member who may need care.

**TTY/TDD** is a communication device for the deaf, speech impaired, or hard of hearing, using a telephone system.

**Urgent care** is any service required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

**Women, Infants, and Children Program (WIC)** is a state nutrition program that helps pregnant women, new mothers and young children eat well and stay healthy.
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. The most recent revision date is shown at the end of this notice.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you’re a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children’s Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs and hospitals so we can OK and pay for your health care.

Federal law says we must tell you what the law says we have to do to protect PHI that’s told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files
  - Destroy paper with health information so others can’t get it
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

When is it OK for us to use and share your PHI?
We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it’s OK. Sometimes, we can use and share it without your OK:

- **For your medical care**
  - To help doctors, hospitals and others get you the care you need
- **For payment, health care operations and treatment**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we’ll pay for health care or services before you get them
- **For health care business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
To find ways to make our programs better

- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt

- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your health care, if you tell us it’s OK
  - With someone who helps with or pays for your health care, if you can’t speak for yourself and it’s best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can’t take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

**Other ways we can — or the law says we have to — use your PHI:**

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we’re asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you’ve asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to workers’ compensation if you get sick or hurt at work

**What are your rights?**

- You can ask to look at your PHI and get a copy of it. We don’t have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don’t have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we’ve shared your PHI with someone else. This won’t list the times we’ve shared it because of health care, payment, everyday health care business or some other reasons we didn’t list here.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.
What do we have to do?
- The law says we must keep your PHI private except as we’ve said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we’ll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you’re in danger.
- We must tell you if we have to share your PHI after you’ve asked us not to.
- If state laws say we have to do more than what we’ve said here, we’ll follow those laws.
- We have to let you know if we think your PHI has been breached.

What if you have questions?
If you have questions about our privacy rules or want to use your rights, please call Customer Service at 1-800-407-4627. If you’re deaf or hard of hearing, call TTY 1-888-757-6034.

What if you have a complaint?
We’re here to help. If you feel your PHI hasn’t been kept safe, you may call Customer Service or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:
Office for Civil Rights
U.S. Department of Health and Human Services
90 Seventh St., Suite 4-100
San Francisco, CA 94103
Phone: 1-800-368-1019
TDD: 1-800-537-7697
Fax: 1-415-437-8329

or
Privacy Officer
c/o Office of HIPAA Compliance
Department of Health Care Services (DHCS)
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Phone: 1-916-445-4646
Fax: 1-916-440-7680
or

Information Security Officer
DHCS Information Security Office
P.O. Box 997413, MS 6400
Sacramento, CA 95899-7413
Email: iso@dhcs.ca.gov
Phone: ITSD Help Desk
1-916-440-7000 or 1-800-579-0874
Fax: 1-916-440-5537
We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we’ll tell you about the changes in a newsletter. We’ll also post them on the Web at www.anthem.com/ca/medi-cal.

Race, ethnicity and language
We receive race, ethnicity and language information about you from the state Medicaid agency and the Children’s Health Insurance Program. We protect this information as described in this notice.

We use this information to:
- Make sure you get the care you need
- Create programs to improve health outcomes
- Develop and send health education information
- Let doctors know about your language needs
- Provide translator services

We do not use this information to:
- Issue health insurance
- Decide how much to charge for services
- Determine benefits
- Disclose to unapproved users

www.anthem.com/ca/medi-cal
Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Blue Cross of California Partnership Plan, Inc. are independent licensees of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Blue Cross of California is contracted with L.A. Care Health Plan to provide Medi-Cal Managed Care services in Los Angeles County.

Revised February 12, 2016
We can translate this at no cost. Call the customer service number on your member ID card.

Podemos traducir esto gratuitamente. Llame al número de servicio al cliente que aparece en su tarjeta de identificación (ID Card).

کلمات ترجمه، ما همیشه، در سرویس مشتریان به شما معرفی می‌کنیم. نام رنگ‌آمیزی در سرویس مشتریان (ID Card) نیست.

Peb b'hais tau qhov no pub dawb. Hu mus rau qhov chaw pab neeg tus naj npawb xov tooj nyob rau ntawm koj daim ID ua mej zeej.

ما ترجمه این را به عنوان ترجمه رایگان به شما معرفی می‌کنیم. نام رنگ‌آمیزی در سرویس مشتریان (ID Card) نیست.

저희는 이것을 무료로 번역해 드릴 수 있습니다. 거복지 ID 카드에 있는 고객 서비스 번호로 연락하십시오.

Мы можем перевести это бесплатно. Позвоните в отдел обслуживания участников плана по номеру, указанному в вашей карточке участника плана (ID Card).

Maaari namit isalin-wika nang walang bayad. Paki tawagan ang numero ng customer service sa inyong ID card na pang miyembro.

Chúng tôi có thể phiên dịch văn bản này miễn phí. Xin gọi văn phòng dịch vụ hỗ trợ trên số điện thoại ghi trên thẻ ID (thẻ hội viên) của quý vị.
Anthem Blue Cross follows Federal civil rights laws. We don’t discriminate against people because of their:

- Race
- Color
- National origin
- Age
- Disability
- Sex

That means we won’t exclude you or treat you differently because of these things.

**Communicating with you is important**

For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic, and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Customer Care Center number on your ID card. Or you can call our Grievance Coordinator at 1-800-407-4627 (TTY 711).

**Your rights**

Do you feel you didn’t get these services or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint). File by mail or phone:

<table>
<thead>
<tr>
<th>For Medi-Cal members in Los Angeles:</th>
<th>For all other Medi-Cal members, Major Risk Medical Insurance Program (MRMIP) members and Medi-Cal Access Program (MCAP) members:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grievance Coordinator</td>
<td>Grievance Coordinator</td>
</tr>
<tr>
<td>Anthem Blue Cross</td>
<td>Anthem Blue Cross</td>
</tr>
<tr>
<td>P.O. Box 9054</td>
<td>P.O. Box 60007</td>
</tr>
<tr>
<td>Oxnard, CA 93031-9054</td>
<td>Los Angeles, CA, 90060-0007</td>
</tr>
<tr>
<td>Phone: 1-888-285-7801 (TTY 1-888-757-6034)</td>
<td>Phone for Medi-Cal: 1-800-407-4627 (TTY 711)</td>
</tr>
<tr>
<td></td>
<td>Phone for MRMIP and MCAP: 1-877-687-0549 (TTY 1-888-757-6034)</td>
</tr>
</tbody>
</table>

**Need help filing?** Call our Grievance Coordinator at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **On the Web:** [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)
- **By mail:** U.S. Department of Health and Human Services
  
  200 Independence Avenue
  
  SW Room 509F, HHH Building
  
  Washington, D.C. 20201
- **By phone:** 1-800-368-1019 (TTY/TDD 1-800-537-7697)

We can translate this at no cost.
Call the customer service number on your member ID card.

<p>| English                                                                 | Arabic                | Armenian       | Burmese       | Chinese       | Farsi       | French       | Fr. Creole | German       | Greek      | Gujarati    | Hebrew     | Hindi       | Hmong       |
|------------------------------------------------------------------------|-----------------------|----------------|---------------|---------------|-------------|--------------|------------|--------------|------------|-------------|------------|-------------|-------------|-------------|</p>
<table>
<thead>
<tr>
<th>Language</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italian</td>
<td>Possiamo effettuare la traduzione gratuitamente. Contatti il numero dell’assistenza clienti riportato sulla Sua tessera identificativa.</td>
</tr>
<tr>
<td>Japanese</td>
<td>私たちは、この文章を無料で翻訳することができます。ご自身のIDカードにあるカスタマーサービス番号へお電話ください。</td>
</tr>
<tr>
<td>Khmer</td>
<td>ដើម្បីសាកល្បងអតិថិជនអាករមួយក្នុងក្រោយប្រព័ន្ធផ្នែក ID របស់អ្នក មានប្រការដូច្នេះ?</td>
</tr>
<tr>
<td>Korean</td>
<td>저희는 이것을 무료로 번역해 드릴 수 있습니다. 카잇자 ID 카드에 있는 고객 서비스 부 번호로 연락하십시오.</td>
</tr>
<tr>
<td>Laotian</td>
<td>ໃຊ້ນສະຖານະລະດັບທີ່ໃຊ້ໃໝ່ຂໍ້ມູນເດັກນີ້. ເຊັກອາດສະຖານະທີ່ລະດັບທີ່ໃຊ້ໃໝ່ທີ່ໃຊ້ໂດຍບໍ່ເປັນປະເທດຂອງຮຽກ.</td>
</tr>
<tr>
<td>Polish</td>
<td>Możemy to przetłumaczyć bez żadnych kosztów. Zadzwoń pod numer obsługi klienta za pomocą karty ID.</td>
</tr>
<tr>
<td>Portuguese</td>
<td>Podemos traduzir isto gratuitamente. Ligue para o serviço de atendimento ao cliente que consta no seu cartão de identificação.</td>
</tr>
<tr>
<td>Russian</td>
<td>Мы можем это бесплатно перевести. Позвоните в отдел обслуживания по телефону, приведенному на вашей идентификационной карточке участника плана.</td>
</tr>
<tr>
<td>Serbian</td>
<td>Možemo to prevesti besplatno. Pozovite na broj korisničkog servisa s Vaše identifikacione kartice (ID).</td>
</tr>
<tr>
<td>Tagalog</td>
<td>Maaari naming ito isalin-wika nang walang bayad. Mangyaring tawagan ang numero ng customer service sa inyong ID card na pang miyembro.</td>
</tr>
<tr>
<td>Thai</td>
<td>เราสามารถแปลได้โดยไม่เสียค่าใช้จ่ายใดๆ ติดต่อหมายเลขโทรศัพท์ของฝ่ายบริการลูกค้าแบบเบื้องต้นของคุณ</td>
</tr>
<tr>
<td>Urdu</td>
<td>بم اس کا ترجمہ مفت کر سکتے ہیں، ایک کل کریں، ID کا کارڈ ہر دیگہ کسی انبہ سروے کے نمبر</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Chúng tôi có thể phiên dịch tài liệu này miễn phí. Xin gọi dịch vụ khách hàng qua số điện thoại giơ trên thẻ ID hội viên của quý vị.</td>
</tr>
<tr>
<td>Yiddish</td>
<td>מיט קנטון דאא איבערעדן פאר', פאא איסטארל. רוחט דער קאנסט렁עarden ספראון</td>
</tr>
</tbody>
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MEMCOMM-0489-16