Major Risk Medical Insurance Program
(MRMIP)

Preferred Provider Organization (PPO)

Service Agreement and Combined Evidence of Coverage and Disclosure Form

IMPORTANT INFORMATION FOR MRMIP SUBSCRIBERS REGARDING MINIMUM ESSENTIAL COVERAGE AND THE HEALTH INSURANCE MARKETPLACE

The Affordable Care Act included a mandate for most individuals to have health insurance or potentially pay a tax penalty for noncompliance. Individuals with insurance needed to make sure their current insurance met Minimum Essential Coverage (MEC) requirements, and they are required to maintain MEC for themselves and their dependents. In February 2015, the federal government granted permanent MEC designation for any State high-risk pool in existence as of November 26, 2014. The Major Risk Medical Insurance Program (MRMIP) is California's high-risk pool. MRMIP subscribers will not need to obtain additional health coverage and will not be subject to tax penalties for noncompliance since MRMIP has been granted permanent MEC designation. The benefit and rate structure will not change due to the MEC designation. This means you have more health insurance choices that meet the federal requirement of minimum essential coverage. The health insurance marketplace options available through Covered California **(coveredCA.com)** and the individual insurance market also meet the federal requirement.

Timely Access to Nonemergency Healthcare Services

Appointment Type	You Should Be Able to Get an Appointment Within:
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours
Urgent care appointment that do require pre-approval (prior authorization)	96 hours
Non-urgent primary care appointments	10 business days
Non-urgent specialist	15 business days
Non-urgent mental health provider or substance use disorder provider (non-doctor)	10 business days
Nonurgent follow-up care with nonphysician mental health providers or substance use disorder provider	10 business days
Non-urgent appointments for ancillary (supporting) services for the diagnosis or treatment of injury, illness, or other health condition	15 business days
Telephone wait times during normal business hours	10 minutes
Triage — 24/7 services	24/7 services — No more than 30 minutes

Long-term services and supports	
Skilled nursing facility	▪ Rural and small counties — within 14 business daysof request ▪ Medium counties — within seven business daysof request ▪ Small counties — within five business days of request
Intermediate care facility/developmentally disabled (ICF-DD)	▪ Rural and small counties — within 14 business days of request ▪ Medium counties — within seven business days of request ▪ Small counties — within five business days of request
Community Based Adult Services (CBAS)	Capacity cannot decrease in aggregate statewide below April 2012 level

The California Department of Managed Health Care (DMHC) adopted new regulations (Title 28, Section 1300.67.2.2) requiring health plans to provide members with timely access to nonemergency healthcare services. Healthcare service plans must implement the policies, procedures and systems necessary for compliance with these regulations.

Please contact 24/7 NurseLine at **800-224-0336** to access triage or screening services by telephone, 24 hours per day, 7 days per week. If you have hearing or speech loss, you may call 24/7 NurseLine TTY line at **711**.

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

Dear Anthem MRMIP member: If you have hearing or speech loss, you may call the TTY line at **888-757-6034**, Monday through Friday, from 8:30 a.m. to 5 p.m., and on weekends, please call the California Relay Service at **711** to get the help you need. We are happy to answer your questions. To make sure the people you speak with are friendly and helpful, we sometimes record phone calls.

Thank you for choosing Anthem. We want to help you be well and stay well.

Sincerely,

Anthem Blue Cross

Major Risk Medical Insurance Program Evidence of Coverage

This Combined Evidence of Coverage (EOC) and Disclosure Form constitute a summary only of the health plan policies and coverage under the Major Risk Medical Insurance Program (MRMIP).

This book tells you how your Anthem Preferred Provider Organization (PPO) health plan works. It also tells you which health services are covered and which ones are not. Please read this book completely and carefully. For easy reference, a benefits summary is included in *Part 5: Benefits summary*. The benefits of this plan only cover medically necessary services. The fact that a physician prescribes or orders a service does not make it medically necessary or a covered benefit. MRMIP coverage is additional to, and does not duplicate, any other medical benefits available to you, whether you claim them or not.

Customer Care Center

Got questions? Call us toll free at **877-687-0549 (TTY 711)**, Monday through Friday, from 8:30 a.m. to 5 p.m. If you have hearing or speech loss, you may call the TTY line at **888-757-6034**, Monday through Friday, from 8:30 a.m. to 5 p.m., and on weekends, please call the California Relay Service at **711** to get the help you need.

Help in other languages

Call us if you need help in another language. We will get someone who speaks your language to answer your questions. If you need someone to explain medical information while you are at your doctor's office, ask your doctor to call us. We'll be glad to help. This help is free.

Eligibility and enrollment information

Information on eligibility, enrollment, open enrollment, disenrollment, the starting date of coverage, transfers of enrollment, and subscriber contributions is included in the MRMIP open enrollment handbook sent to you by the program. If you have questions on these topics, or would like another copy of the open enrollment handbook, please contact the MRMIP at:

CALIFORNIA MAJOR RISK MEDICAL INSURANCE PROGRAM
P.O. BOX 9044
OXNARD, CA 93031-9044
800-289-6574

The MRMIP application and handbook is also available online at **DHCS.ca.gov**.

Annual deductible information

The MRMIP has an annual $500 deductible per member or per family. You must pay for certain healthcare services up to $500 before the plan will begin paying for covered services that apply to the deductible. The annual deductible applies for a calendar year beginning January 1. After you meet the deductible and for the remainder of the calendar year, you pay only the applicable copayment or coinsurance up to the annual out-of-pocket maximum. Payments for services provided by in-network and out-of-network providers and costs for prescription drug payments apply toward the $500 annual

deductible. You do not have to meet the deductible before receiving coverage for preventive care services. Your payments for preventive care services do not apply towards the $500 annual deductible. Please refer to the *Deductible* section of this EOC booklet for more information.

Contents

Customer Care Center: **877-687-0549**
TTY: **888-757-6034**
24/7 NurseLine: **800-224-0336**
TTY: **711**
TTY lines are for members with hearing or speech loss only.
anthem.com/ca/medi-cal

Part 1 How to use your Anthem PPO health plan

As a member of the Anthem PPO health plan, you are entitled to a wide range of medical benefits. These benefits are outlined in *Part 4: What Anthem covers.* You may also refer to the table in *Part 5: Benefits summary*, for an at-a-glance view of your benefits and any limitations related to services.

Using your Anthem PPO ID card

Your Anthem member identification (ID) card not only identifies you, but also lists important phone numbers. Carry your ID card with you at all times and present it whenever you seek medical care or services. You can find your effective date of coverage on your ID card. This is the date your healthcare benefits started with Anthem. You, and your enrolled dependents, are the only people who can get healthcare services under your Anthem PPO card number. Your enrolled dependents will not receive an ID card with their name. If you let someone else use your ID card, your coverage could be terminated. The following phone numbers for plan information and services appear on your card:

- Anthem Customer Care Center – **877-687-0549**
- Anthem Customer Care Center TTY – **888-757-6034**
- Anthem Utilization Review – **877-273-4193**
- Anthem Pharmacy Management (administered by CarelonRx) – **833-419-0530**

Choosing doctors

The Anthem PPO health plan gives you access to care through a network of physicians, hospitals, and selected ambulatory surgical centers, infusion therapy, and durable medical equipment providers. Using network providers ensures maximum member savings.

Anthem has a Prudent Buyer program with a complete listing of providers in the Anthem network. This listing is an easy way to find the medical care you need within the network.

You can get a provider listing by calling Anthem or through our website at **https://mss.anthem.com/california-medicaid/care/find-a-doctor.html**.

If you are currently seeing a doctor who is not an Anthem doctor, you may be able to continue seeing that doctor. If you have an acute or serious chronic condition, you may be able to receive services from your doctor until those services are completed or until you can transfer safely to another doctor. This is called *continuity of care.* You may also continue to see a nonparticipating doctor when you join Anthem. This is called *transition assistance for new members.*

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Anthem Customer Care Center to ensure that you can obtain the healthcare services that you need.

Continuity of care

If your doctor stops working with Anthem, we will let you know by mail 60 days before the doctor's last day. Subject to the terms and conditions set forth below, Anthem will pay benefits at the participating provider level for covered services (subject to applicable copayments and other terms) given to a member by a provider whose participation we have terminated.

You must be under the care of the participating provider at the time of the termination. The terminated provider must agree in writing to provide services to the member in accordance with the terms and conditions of his/her agreement with Anthem prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.

Anthem will furnish such benefits for the continuation of services by a terminated provider only for the following conditions:

- An acute condition
  - An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration.
  - Covered services are provided for the duration of the acute condition.
- A serious chronic condition
  - A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
  - Covered services are provided to complete a course of treatment and to arrange for a safe transfer to another provider. The duration of these services is agreed upon by Anthem, the member and the terminated provider and must be consistent with good professional practice.
  - Covered services shall not exceed 12 months from the provider's contract termination date.
- A pregnancy
  - A pregnancy includes the three trimesters of pregnancy and the immediate postpartum period.
  - Covered services are provided for the duration of the pregnancy.
- A terminal illness
  - A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.
  - Covered services are provided for the duration of the terminal illness.
- The care of an actively enrolled newborn child between birth and age 36 months

– Covered services shall not exceed 12 months from the provider's contract termination date.

- Performance of a surgery or other procedure we authorized as part of a documented course of treatment and was recommended and documented by the provider to occur within 180 days of the provider's contract termination date. Such benefits will not apply to providers terminated due to medical disciplinary cause or reason, fraud or other criminal activity.

Please call our Customer Care Center or TTY phone number to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the agreement.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for continuation of care is approved.

If approved, the member will be financially responsible only for applicable copayments under this plan. Financial arrangements with terminated providers are negotiated on a case-by-case basis. We will request that the terminated provider agree to negotiate reimbursement and/or contractual requirements that apply to participating providers, including payment terms. If the terminated provider does not agree to the same reimbursement and/or contractual requirements, we are not required to continue that provider's services. If you disagree with our determination regarding continuation of care, see *Part 8: How to Resolve a Problem with Anthem.*

Transition assistance for new members

Transition assistance is a process that allows for continuity of care for new members receiving services from a nonparticipating provider. If you are a new member, you may request transition assistance if any of the following conditions exist:

- An acute condition
  - An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration.
  - Covered services are provided for the duration of the acute condition.
- A serious chronic condition
  - A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
  - Covered services are provided to complete a course of treatment and to arrange for a safe transfer to another provider. The duration of these services is agreed upon by Anthem, the member and the nonparticipating provider and must be consistent with good professional practice.
  - Covered services shall not exceed 12 months from the time the member enrolls with Anthem.

- A pregnancy
  - A pregnancy includes the three trimesters of pregnancy and the immediate postpartum period.
  - Covered services are provided for the duration of the pregnancy.
- A terminal illness
  - A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.
  - Covered services are provided for the duration of the terminal illness.
- The care of an actively enrolled newborn child between birth and age 36 months
  - Covered services shall not exceed 12 months from the time the member enrolls with Anthem.
- Performance of a surgery or other procedure we authorized as part of a documented course of treatment and was recommended and documented by the provider to occur within 180 days of the time the member enrolled with Anthem.

Call our Customer Care Center or TTY phone number to request transition assistance or to obtain a copy of the written policy. Eligibility is based on the member's clinical condition; it is not determined by diagnostic classifications. Transition assistance does not provide coverage for services not otherwise covered under the agreement.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for transition assistance is approved.

If approved, you will be financially responsible only for applicable copayments under this plan. Financial arrangements with nonparticipating providers are negotiated on a case-by-case basis. We will request the nonparticipating provider agree to negotiate reimbursement and/or contractual requirements that apply to participating providers, including payment terms. If the nonparticipating provider does not agree to negotiate, we are not required to continue that provider's services. If you do not meet the criteria for transition assistance, you will be afforded due process including having a physician review the request. If you disagree with our determination regarding transition assistance for new members, see *Part 8: How to resolve a problem with Anthem.*

Many benefits are available out-of-network

Except for hospital services, you may receive services outside the network. Please see *Referral to Specialists* and *Member Liabilities* farther on in this section. You will pay a much greater share of the costs when you use a nonparticipating provider. You will also be responsible for a larger coinsurance and any charges that exceed the fee schedule. While Anthem contracts with most hospitals in California, Anthem does not contract with all of them. Anthem will not cover services from a noncontracting hospital except in a medical emergency.

Making an appointment with the doctor

Call the doctor's office for an appointment and tell them you are an Anthem PPO member. Have your Anthem ID card ready when you call. The office staff may ask for the numbers on the card.

You can reach an Anthem doctor 24 hours a day. If you call after office hours, leave your name and telephone number with the answering service and your doctor or a doctor on call will get back to you.

When you have an appointment, be on time. Call your doctor's office as soon as possible if you are going to be late or you are unable to make it to your appointment. This will help your doctor reduce everyone's time in the waiting room.

Anthem providers have ramps, restrooms, parking spaces and elevators for disabled members so they can get the healthcare they need.

Getting a second medical opinion

You might have questions about a treatment or surgery that your doctor says you need. You may want a second opinion. Second opinions are helpful if:

- You have questions about a recommended surgery.
- You have questions about a finding or treatment plan for a chronic condition or a condition that could cause loss of life, limb, or bodily function, or could substantially impair your health.
- Your doctor's advice is not clear or is too complex.
- The diagnosis given is not consistent with the test results.
- Your doctor cannot diagnose your medical condition.
- A treatment plan is not improving your condition.
- You are concerned about your doctor's treatment plan or diagnosis.

You should, but are not required to, speak to your primary care provider if you want a second opinion. You should get a second opinion from a qualified healthcare provider. If you need a second opinion for specialty care, it is best to see a doctor of the same specialty. You do not need prior authorization for a second opinion.

The second opinion visit is a covered benefit. Should you decide to seek a second opinion, remember, you get the most from your benefits when you see a participating provider. Your doctor can refer you to a participating provider for a second opinion. If you choose a nonparticipating provider, you will pay a greater share of the costs, and you will be responsible for a larger coinsurance as well as any charges that exceed the fee schedule.

For more information about second opinions, call our Customer Care Center or TTY phone number. You also may call 24/7 NurseLine, a confidential nurse help line. The phone number and TTY line for 24/7 NurseLine are listed at the bottom of the page.

Prior authorization (an OK by Anthem)

Anthem requires prior authorization, an OK ahead of time to determine if some services are medically necessary. Your doctor may need to get prior authorization from us to make sure we will cover some

services. These services include:

- All inpatient hospital care except for childbirth, mastectomy, and reconstructive surgery secondary to mastectomy
- All infusion therapies (except blood and blood products)
- All high-cost radiology such as CT, MRI, MRA, PET, and SPECT
- All organ and tissue transplants
- Home healthcare
- Hospice
- Septoplasty
- Special food products

Sometimes we will ask the doctor why you need special care. You can call and ask us how we make our prior authorization decisions.

You should know:

- We do not reward practitioners or other individuals conducting utilization review for denying coverage or services.
- We do not offer financial incentives for utilization management decision–makers to encourage decisions that result in underutilization, such as reduction in or denial of a requested service.
- Utilization Management decision making is based only on appropriateness of care and service and existence of coverage

The doctor will do his or her best to give all the covered services you need in a way that reflects your wishes.

You can refuse his or her advice about a treatment plan. If the doctor is worried about your choice, you will be advised. No doctor has to give you treatment that he or she doesn't think is right.

Anthem works with you and your doctors to cover medically necessary and proper care and services. A medical necessity review may have several different names, including a utilization review (UR), utilization management (UM) review, medical management review, or care management review. For information on how our utilization review process works, please call us.

Referrals to specialists

When you need a specialist, you may go to any doctor. If you choose a participating provider in the Anthem Prudent Buyer provider listing, this ensures maximum member savings. If you choose a nonparticipating provider, you will pay a larger portion of the cost because you will be responsible for a larger coinsurance and any charges that exceed the fee schedule.

We would like to remind you to make sure all providers you select are part of the Prudent Buyer provider network. The network consists of physicians and hospitals statewide that have negotiated contracts with Anthem to provide covered healthcare services to you at discounted rates.

With the state's largest network of healthcare providers, comprising more than 40,000 physicians and over 400 hospitals, you are assured of easy access to Prudent Buyer providers, and you have no claims to fill out.

Please call our Customer Care Center or TTY phone number to verify provider participation, or to request a Prudent Buyer Plan Provider Listing for your area. You can also verify participating providers through our website at **https://mss.anthem.com/california-medicaid/care/find-a-doctor.html**.

If you use a nonparticipating provider, it is likely you will pay substantially greater out-of-pocket costs. Staying in the Prudent Buyer network can save you money.

Member liabilities

Generally, the only amount a member pays for covered services is the required copayment or coinsurance.

You may have to pay for services you receive that are NOT covered services, such as:

- Nonemergency services received in the emergency room
- Nonemergency or nonurgent services received outside of Anthem service area if you did not get authorization from Anthem before receiving such services
- Specialty services you received if you did not get a required referral or authorization from Anthem before receiving such services. See *Part 1: Prior authorization (an OK by Anthem.)*
- Services from a nonparticipating provider, unless the services are for situations allowed in this EOC (for example, emergency services, post-stabilization services if you or your spouse or legal guardian refuse transfer to a participating hospital and you or your spouse or legal guardian receive appropriate written notice of your financial responsibility; urgent services outside the plan's service area; or specialty services approved by the plan).

See *Part 1: Prior authorization (an OK by Anthem*); or

- Services you received that are greater than the limits described in this EOC unless authorized by Anthem

Anthem is responsible to pay for all covered services including emergency services. You are not responsible to pay a provider for any amount owed by the health plan for any covered service.

If Anthem does not pay a nonparticipating provider for covered services, you do not have to pay the nonparticipating provider for the cost of the covered services. Covered services are those services that are provided according to this Evidence of Coverage booklet or as otherwise required by law. The nonparticipating provider must bill Anthem, not you, for any covered service. But remember, services from a nonparticipating provider are not "covered services" unless they fall within the situations allowed by this Evidence of Coverage booklet.

If you receive a bill for a covered service from any provider, whether participating or nonparticipating, contact the Anthem Customer Care Center department at **877-687-0549** Monday through Friday from 8:30 a.m. to 5 p.m. If you have hearing or speech loss, you may call our TTY line at **888-757-6034**.

Pre-existing condition exclusion period

There is a pre-existing condition exclusion period of three months from your effective date. During this period, no benefits or services related to a pre-existing condition are covered unless this pre-existing condition exclusion period is waived or reduced at the time of your enrollment in this plan. *Pre-existing condition* means an illness, injury, disease, or physical condition for which medical advice, diagnosis, care,

or treatment, including the use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the member's effective date of coverage.

Coordination of benefits

If you are covered by another health plan, please call our Customer Care Center or TTY phone number. If you need healthcare services, your other health plan will pay first and Anthem will pay second. The total of the two payments cannot be more than the total amount allowed by Anthem.

Cost sharing (Deductibles, Copayments, and Coinsurance)

When you receive covered services, you are responsible for your cost-sharing amount as described in the benefits description section. If you receive more than one service from a provider, or services from more than one provider, you may be required to pay separate cost-sharing amounts for each service and each provider. For example, if a member uses a participating provider and receives a preventive service such as a mammogram, the member will pay a 15 percent coinsurance for the mammogram and a $25 copayment for professional services/physician office visit. If you have questions, call us.

Deductible

Anthem has an annual $500 deductible you must satisfy before the plan will begin paying for covered services. Effective each January 1st, you are responsible for charges for certain covered services subject to the deductible and Anthem will not cover these services until you meet the deductible in a calendar year. The only payments that count toward a deductible are those you make for covered services that are subject to the deductible.

After you meet the deductible and for the remainder of the calendar year, you pay only the applicable copayment or coinsurance subject to the yearly maximum copayment/coinsurance limit. Payments for services provided by in-network and out-of-network providers and prescription payments apply toward the $500 annual deductible.

The following preventive care services are covered even if you have not met your deductible and do not apply toward the annual deductible:

- Breast exams and mammograms
- Pap smears, pelvic exams, and ovarian and cervical cancer screenings
- Human papillomavirus (HPV) screening test
- Human immunodeficiency virus (HIV) testing
- Cytology examinations on a reasonable periodic basis
- A variety of voluntary family planning services
- Health education
- Periodic health exams and laboratory services in connection with them
- Vision and hearing tests for children
- Newborn blood tests
- Prenatal care (care during pregnancy)
- Prostate exams for men

- Sexually transmitted disease (STD) tests
- Well-baby and well-child visits
- Immunizations for children and adults, including immunizations needed for travel

You will receive an explanation of benefits (EOB) each time you receive covered services. This EOB will tell you the amount applied to the deductible, if the deductible applies. The EOB will also tell you the amount you have paid toward the annual deductible. After you meet the deductible, the EOB will tell you the amount of copayment or coinsurance you pay. You also can obtain the deductible information and the annual maximum copayment/coinsurance amount by calling our Customer Care Center or TTY phone number.

Copayments

You may be required to pay a copayment for services received while you are covered under this plan. Your copayment is a fixed dollar amount per service.

Coinsurance

You may be required to pay a coinsurance for services received while you are covered under this plan. Coinsurance is a percentage of the fee negotiated by Anthem for services received from a participating provider, or the customary and reasonable charges as established by Anthem for services you receive from a nonparticipating provider. If you receive services from a nonparticipating provider, you also will have to pay any charges in excess of the customary and reasonable charges. See *Part 5: Benefits summary*, to determine your copayment or coinsurance responsibility for covered services.

Coinsurance paid to nonparticipating providers is not applied toward the Anthem-participating provider yearly maximum copayment/coinsurance limit, except for emergency medical services. You will be responsible to pay the coinsurance amounts for nonparticipating providers even after you reach your participating provider yearly maximum copayment/coinsurance limit.

Yearly maximum copayment/coinsurance limit

The yearly maximum copayment/coinsurance limit for participating providers is $2,500 per member per calendar year and $4,000 per family per calendar year. Once an enrolled member or family has paid the yearly maximum in copayments or coinsurance in a calendar year, no further copayment or coinsurance will be required for participating providers for the remaining calendar year.

There is **no** yearly maximum copayment/coinsurance limit for nonparticipating providers. Applicable coinsurance for nonparticipating providers will continue to apply throughout the calendar year. We will **not** apply coinsurance paid to nonparticipating providers toward the yearly maximum copayment/coinsurance limit for participating providers, except for emergency medical services. There are MRMIP payment limits of $75,000 per calendar year per member and $750,000 in a lifetime per member. Any current and/or previous benefits received under the MRMIP shall count towards the $750,000 lifetime maximum.

Annual maximum benefit limit

The combined total of all benefits paid under the MRMIP for expenses incurred by a member in each calendar year is limited to a maximum amount of $75,000. These benefits are payable only for covered expenses incurred while the member's coverage under this plan is in effect.

Lifetime maximum benefit limit

The combined total of all benefits paid under the MRMIP for expenses incurred by a member is limited to a maximum amount of $750,000 in the member's lifetime. These benefits are payable only for expenses incurred while the member's coverage under this plan is in effect. Any current and/or previous benefits received under the MRMIP shall be counted toward the $750,000 lifetime maximum. Any additional limits on the number of visits or days covered are stated in *Part 4: What Anthem covers,* under the specific benefit.

Part 2 Emergency and urgent care services

What is an emergency?

An emergency condition is a medical or psychiatric condition with such severe symptoms (including severe pain or active labor) that a prudent layperson who has an average knowledge of health and medicine, could reasonably believe the lack of immediate medical attention could:

- Place your health or the health of your unborn baby in serious jeopardy
- Cause serious impairment to bodily functions
- Cause serious dysfunction of any bodily organ or part

Examples include:

- Chest pain
- Heavy bleeding
- Difficulty breathing or shortness of breath
- Sudden loss of consciousness
- Active labor
- Sudden weakness or numbness of the face, arm or leg on one side of the body
- Psychiatric medical emergency conditions

We cover emergency services whether you receive them inside or outside of your service area. Outside of your service area, treatment for emergencies includes urgently needed services to prevent serious deterioration of your health resulting from unforeseen illness or injury, and treatment cannot be delayed until you return to your service area. These urgently needed services will also be covered.

It is important that you or your doctor call Anthem within 48 hours (or as soon as reasonably possible) if you are admitted to a hospital in an emergency situation.

If you believe that you are having a medical emergency, call 911.

What to do if you are not sure you have an emergency

If you are not sure whether you have an emergency or require urgent care, your medical group or PCP may be reached 24 hours a day. Either your own doctor will call you back, after you leave your name and telephone number with the answering service, or a doctor on call will get back to you with the medical advice you need. If you are not sure whether you have an emergency or require urgent care, please contact 24/7 NurseLine, the 24-hour nurse health information line to access triage or screening services 24 hours a day, 7 days a week. The 24/7 NurseLine number is **800-224-0336**. If you have speech or hearing loss, you may call the 24/7 NurseLine TTY line at **711**.

Post-stabilization and follow-up care after an emergency

Once your emergency medical condition has been treated at a hospital and an emergency no longer exists because your condition is stabilized, the doctor who is treating you may want you to stay in the hospital for a while longer before you can safely leave the hospital. The services you receive after an

emergency condition is stabilized are called *post-stabilization services*.

If the hospital where you received emergency services is not part of Anthem' contracted network, the non-contracted hospital will contact Anthem to get approval for your stay in the non-contracted hospital.

If Anthem approves your continued stay in the non-contracted hospital, you will not have to pay for services except for any coinsurance normally required by Anthem.

If Anthem has notified the non-contracting hospital that you can safely be moved to one of the plan's contracted hospitals, Anthem will arrange for and pay for you to be moved from the non-contracted hospital to a contracted hospital.

If Anthem determines that you can be safely transferred to a contracted hospital, and you or your spouse or legal guardian do not agree to you being transferred, the non-contracting hospital must give you or your spouse or legal guardian a written notice stating that you will have to pay for all of the costs for post-stabilization services provided to you at the non-contracted hospital after your emergency condition is stabilized.

Also, you may have to pay for services if the non-contracted hospital cannot find out what your name is and cannot get contact information at the plan to ask for approval to provide services once you are stable.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR POST-STABILIZATION SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED HOSPITAL, PLEASE CONTACT THE ANTHEM CUSTOMER CARE CENTER AT 877-687-0549 MONDAY THROUGH FRIDAY FROM 8:30 A.M. TO 5 P.M. IF YOU HAVE HEARING OR SPEECH LOSS, YOU MAY CALL OUR TTY LINE AT 888-757-6034.

What to do when you need urgent care services

An urgent medical condition is not an emergency, but may require prompt medical attention. Call your doctor or 24/7 NurseLine if you think you have an urgent medical condition.

For more information about emergency and urgent care services, please see *Emergency healthcare services* in *Part 4: What Anthem covers.*

Follow-up care

After you receive emergency or urgent care services, please call your physician for follow-up care.

Non-covered services

Medical services provided in an emergency or urgent care setting for conditions that are not emergencies or urgent are not covered under this plan. You will be responsible for all charges related to these services.

Part 3 Accessing care

Physical access

Anthem has made every effort to ensure that our offices and the offices and facilities of Anthem providers are accessible to the disabled. If you are not able to locate an accessible provider, please call our Customer Care Center or TTY phone number and a Customer Care Center representative will help you find an alternative provider who meets your needs.

Help for members who do not speak English

If you do not speak English and need help during your doctor visit, you can get help in your language 24 hours a day. Just call our toll-free Customer Care Center number or TTY line and ask for a face-to-face or phone interpreter at no cost to you. We will get someone who can speak your language. If you need someone to interpret for you while you are at your doctor's office, ask your doctor to call us 72 hours in advance. We will be glad to help. We suggest that you use an interpreter who speaks your language so you do not have to use a family member or a friend to translate for you. You can call 24/7 NurseLine if you need someone to interpret for you after regular office hours.

If services are not given to you in the language you ask for, you may file a complaint with this health plan. To learn more, see *Part 8: How to resolve a problem with Anthem.*

Access for members with hearing or speech loss

We have a toll-free number for members with hearing or speech loss (a TTY line). That number is **888-757-6034**. The TTY line is open from 8:30 a.m. to 5 p.m. Monday through Friday, and on weekends, please call the California Relay Service at **711** to get the help you need.

Access for members with vision loss

Members with vision loss can get this EOC, letters and other important plan materials in other formats such as:

- Large print
- Computer disk format (CD)
- Braille
- Audio CD

To get these other formats or for help reading this EOC, letters or other plan materials, call our toll-free Customer Care Center or TTY phone number. If you do not receive written information in the language you ask for, you may file a complaint with this health plan. To learn more, see *Part 8: How to resolve a problem with Anthem.*

The Americans with Disabilities Act of 1990

Anthem complies with the American with Disabilities Act of 1990 (ADA). This federal law protects you from being treated in a different way by your health plan because you are disabled. Section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall be excluded, based on disability, from participation in any program or activity that receives or benefits from federal financial assistance,

nor be denied the benefits of, or otherwise be subjected to, discrimination under such a program or activity.

Disability access grievances

If you believe Anthem or network providers have failed to respond to your disability access needs, you may file a grievance with Anthem by calling our Customer Care Center or TTY phone number. If your disability access complaint remains unresolved, you may contact the DHCS at:

Office of Civil Rights
Department of Health Care Services
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Phone: 916-440-7370

If you have hearing loss, you may call the California Relay Service at **TTY 711**.

Email: **CivilRights@dhcs.ca.gov**

Part 4 What Anthem covers

The benefits described in this EOC apply to the covered expenses for treatment of a covered illness, injury, or condition that occurs while you are a member of this plan. Services are covered only if they are:

- Performed or prescribed by a provider acting within the scope of licensure
- Covered benefits
- Medically necessary

If you have any questions about what is covered, call our Customer Care Center or TTY phone number.

Claims and Customer Care Center

To submit medical claims, send Anthem a completed member claim form, a copy of services rendered by the provider, your receipts (or other documents showing proof of payment), and proof of medical necessity to:

Anthem Blue Cross
Major Risk Medical Insurance Program
P.O. Box 60007
Los Angeles, CA 90060-0007

You can request a member claim form by calling us. For information about prescription claims submissions, see *Part 7: How to Get Prescription Drugs.*

Benefit limitations

Some of the services listed in this section have limited benefits, such as maximum day or visit limitations (for example, psychiatric services for mental or nervous disorders). You will be responsible for any amount exceeding the maximum day or visit limitation. Services related to a pre-existing condition, recommended or received on or within three months after your effective date are **not** covered unless this pre-existing condition exclusion period is waived or reduced at the time of enrollment in this plan. The pre-existing condition exclusion period may be reduced by creditable coverage. Please see the definition of creditable coverage in *Part 11: Definitions.*

Copayments and coinsurance is applied to the deductible, with the exception of preventive care services.

Alcohol and Drug Abuse – Inpatient (coinsurance applies)

Requires Prior Authorization

We cover hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the body.

Ambulance services (coinsurance applies)

We cover emergency services given by a licensed ambulance company or air ambulance to the first hospital that accepts you for emergency care. This includes services provided through the 911 emergency system.

If you believe you are having a medical emergency, call **911**. Ambulance charges, when requested through a 911 call, are covered if you reasonably believe a medical emergency exists even if you are not transported to a hospital.

Nonemergency transportation for transfer from one hospital to another hospital or facility, or from a facility to home, is covered as long as the service is:

- Medically necessary
- Requested by a doctor
- OK'd in advance by Anthem

Excluded is coverage for transportation by airline, passenger car, taxi or other form of public transport.

Blood and blood products (coinsurance applies)

We cover processing, storage and administration of blood and blood products in inpatient and outpatient settings. This includes the collection and storage of autologous blood when medically indicated.

Cancer clinical trials (coinsurance applies)

Requires Prior Authorization for Inpatient Care

If you have cancer and are accepted into a Phase I, Phase II, Phase III, or Phase IV cancer clinical trial, then:

- We cover all routine healthcare costs related to the clinical trial the same as any other medical condition.
- Your doctor must refer you to the trial and we must approve your participation as well.
- The clinical trial must help you get better and not just test how sick you are.
- You must be cared for by a participating doctor in California unless the clinical trial is not offered at a California hospital or by a California doctor.
- Benefits are subject to any applicable copayments.

When a doctor outside the network provides covered services for a clinical trial, we will pay that doctor a fee agreed upon by us and the doctor. This fee is subject to the applicable copayments; however, you will have to pay charges over that fee rate.

Drugs used to treat your illness must be exempt under federal regulation from a new drug application or be approved by any of these agencies:

- National Institutes of Health
- The Food and Drug Administration (FDA)
- The U.S. Department of Defense
- The U.S. Department of Veterans Affairs

- We cover most common services not provided by the clinical trial including healthcare services that are:
  - Normally provided absent a clinical trial
  - Required for getting the investigational drug, item, device, or service
  - Required for the clinically appropriate monitoring of the investigational drug, item, device, or service
  - Provided for preventing medical problems that may occur from using the investigational drug, item, device, or service
  - Needed as a result of providing the investigational drug, item, device, or service, including finding or treating complications

We do not cover:

- Drugs or devices associated with the clinical trial that have not been approved by the FDA
- Nonclinical services such as travel, housing, companion costs, or any other nonclinical expense incurred as a result of the treatment being provided in the clinical trial
- Any item or service not used to manage your health, such as that which is provided solely for data collection and analysis
- Services provided in the clinical trial that are listed in *Part 6: What Anthem Does Not Cover*
- Services customarily provided by the research sponsors free of charge to you

Cataract spectacles and lenses (coinsurance applies)

We cover cataract spectacles, cataract contact lenses or intraocular lenses that replace the natural lens of the eye after cataract surgery. One pair of conventional eyeglasses or conventional contact lenses is covered if necessary after cataract surgery with insertion of an intraocular lens.

Dental injury treatment (coinsurance applies)

A physician (MD) or dentist (DDS or DMD) may treat you for an accidental injury to natural teeth or your jaw if the injury occurs while you are covered under this plan. Services must begin within 90 days after the date you are injured or as soon as medically possible.

We cover general anesthesia and associated facility charges in connection with dental procedures rendered in a surgery center setting when the clinical status or underlying medical condition of a member requires dental procedures that ordinarily would not require general anesthesia in a surgery center setting.

This benefit is available only to members under 7 years of age; the developmentally disabled, regardless of age; and members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. Damage to natural teeth caused by chewing or biting is not an accidental injury and is excluded.

Diabetes treatment (coinsurance applies)

We cover diabetes self-management training to members diagnosed with diabetes. This includes nutritional counseling and the proper use of diabetes equipment and supplies.

A healthcare practitioner or provider licensed, registered or certified in California to provide appropriate healthcare services must offer the diabetes self-management training.

We will authorize additional training if a doctor or other healthcare practitioner diagnoses a significant change in the qualified member's symptoms or condition that requires changes in the qualified member's self-management regime.

We also cover periodic or episodic continuing education when prescribed by an appropriate healthcare practitioner as warranted by the development of new techniques and treatments for diabetes.

The following diabetes equipment and supplies are covered:

- Glucose monitors, including monitors designed to assist those with vision loss
- Blood glucose testing strips
- Insulin pumps and all related necessary supplies
- Urine ketone testing strips
- Lancets and lancet puncture devices and test strips used to monitor diabetes
- Pen delivery systems for the administration of insulin
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent and treat diabetes-related complications
- Insulin syringes
- Visual aids, excluding eyeglasses, to assist those with vision loss to give themselves proper dosing of insulin

Diagnostic X-ray and laboratory services (coinsurance applies)

We cover outpatient diagnostic laboratory services, diagnostic and therapeutic radiology services, and other diagnostic services including, but not limited to, nuclear medicine, ultrasound, electrocardiography, and electroencephalography.

All high-cost radiology such as CT, MRI, MRA, PET, and SPECT requires prior authorization, with the exception of services performed as part of an emergency.

Durable Medical Equipment and supplies (coinsurance applies)

We cover medical equipment appropriate for use in the home that is intended for repeat use, is generally not useful to a person who is not ill or injured, and primarily serves a medical purpose. Call us for a list of covered durable medical equipment or if you have a question about renting or purchasing standard equipment.

The following equipment and supplies are covered:

- Oxygen and oxygen equipment
- Apnea monitors

- Pediatric and adult asthma supplies such as nebulizer machines, face masks, tubing and related supplies, spacer devices for metered dose inhalers, and peak flow meters
- Ostomy supplies
- Urinary catheters and supplies
- Long-lasting medical equipment and supplies such as wheelchairs or walkers
- Repair or replacement, unless necessitated by misuse or loss

All special food products require prior authorization.

Emergency healthcare services (coinsurance applies)

An emergency condition is a medical or psychiatric condition with such severe symptoms (including severe pain or active labor) that a prudent layperson (not a medical professional) who has an average knowledge of health and medicine, could reasonably believe the lack of immediate medical attention could:

- Place your health or the health of our unborn baby in serious jeopardy
- Cause serious impairment to bodily functions
- Cause serious dysfunction of any bodily organ or part

If you believe that you are having a medical emergency, you should call 911.

The following emergency healthcare services are covered:

- Emergency ambulance transportation, including transportation provided through the 911 emergency response system
- Emergency room services
- Psychiatric emergency medical screenings and treatment
- Hospital services, including services at an ambulatory surgical center
- Professional services
- Supplies

Emergency services are covered both in and out of the plan's service area and in the plan's participating or any non-participating facilities. Outside of your service area, treatment for emergencies includes urgently needed services to prevent serious deterioration of your health resulting from unforeseen illness or injury, and treatment cannot be delayed until you return to your service area. These urgently needed services will also be covered.

Ambulance charges, when requested through a 911 call, are covered if you reasonably believe that a medical emergency exists even if you are not transported to a hospital.

It is important that you or your doctor call Anthem within 48 hours (or as soon as reasonably possible) if you are admitted to a hospital in an emergency situation.

If the member's medical condition prohibited transfer to a participating facility within 48 hours, the member's coinsurance will remain at 15 percent of customary and reasonable charges or billed charges, whichever is less, plus any charges in excess of customary and reasonable charges until his/her medical condition permits transfer to a participating facility.

Medical services provided in emergency or urgent care settings for conditions that are neither an emergency nor urgent are not covered under this plan. You will be responsible for all charges related to these services.

Family planning services (coinsurance applies)

Copays for family planning services do not apply to your annual deductible.

The following family planning services are covered:

- Prescription contraception methods approved by the FDA (See *Part 7: How to get prescription drugs*)
- Family planning counseling
- Contraceptive services, including emergency contraception
- Sterilization, including tubal ligation and vasectomy

Foreign country providers (coinsurance applies)

We cover all emergency services you receive while you are out of the country, including emergency ambulance transportation; emergency room services; emergency psychiatric medical screening and treatment; hospital services, including services at an ambulatory surgical center; professional services; supplies and prescription drugs.

Outside of your service area, treatment for emergencies includes urgently needed services to prevent serious deterioration of your health resulting from unforeseen illness or injury, and treatment cannot be delayed until you return to your service area. These urgently needed services will also be covered.

Medical services provided in emergency or urgent care settings for conditions that are not emergencies or urgent are not covered under this plan. You will be responsible for all charges related to these services.

If you are traveling outside the U.S. and need emergency or urgent care services, you may have to pay the bill and then we will reimburse you. Please ask the provider for an itemized bill (written in English). You are responsible, at your expense, for obtaining an English language translation of the bill and any medical records that may be required. Submit the claim and medical records to:

Anthem Blue Cross
Major Risk Medical Insurance Program
P.O. Box 60007
Los Angeles, CA 90060-0007

Home healthcare (coinsurance applies)

Requires Prior Authorization

We cover healthcare services provided in the home by healthcare personnel. This includes visits by registered nurses, licensed vocational nurses, and home health aides; physical, occupational and speech therapists; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of

his or her licensure.

Home health services are limited to those services that are prescribed or directed by the attending physician or other appropriate authority designated by Anthem.

If a basic healthcare service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority chosen by Anthem to decide on the setting for that care. Anthem shall exercise prudent medical case management to ensure that appropriate care is given in the appropriate setting.

Medical case management may include consideration of whether or not a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or settings.

Hospice (coinsurance applies)

Requires Prior Authorization

This coverage is for an individual who has a terminal disease or a terminal illness and is not expected to live for more than 12 months if the disease or illness follows its natural course.

Hospice services mean palliative care and care to alleviate physical, emotional, social, and spiritual discomfort for a patient in the last phases of life if the patient has a terminal disease or illness. These services also include supportive care for the patient's primary caregiver and the patient's family. Only an entity licensed under the California Hospice Licensure Act of 1990, or a licensed home health agency with federal Medicare certification, may provide hospice services; however, the hospice may arrange with appropriately licensed individuals or other entities to provide hospice services.

If you elect hospice services for a terminal disease or illness, you also will be entitled to services from your attending physician, if he or she is not an employee of the hospice, and to services provided through the hospice. If you make a hospice election, you may revoke it at any time.

Hospice services include the following specific services:

- Interdisciplinary team care with development and maintenance of an appropriate plan of care
  - An interdisciplinary team is a hospice care team that includes the patient, the patient's family, a physician, a registered nurse, a social worker, a volunteer, and a spiritual caregiver
  - A plan of care is a written plan that addresses the patient's needs and the needs of the family admitted to the hospice program
- Skilled nursing services, certified home health aide services, and homemaker services under the supervision of a qualified registered nurse including:
  - Palliative, supportive services required by a patient with a terminal disease or illness
  - Assessment, evaluation, and case management of the patient's medical nursing needs, the performance of prescribed medical treatment for pain and symptom control, emotional support for the patient and his or her family, and the instruction of caregivers in providing personal care to the patient
  - Home health aide services provided for the personal care of a terminally ill patient and related tasks in the patient's home under the plan of care to increase the level of comfort and maintain

personal hygiene and a safe, healthy environment for the patient
  – Homemaker services to maintain a safe and healthy environment for the patient and to help the patient carry out the treatment plan
- Bereavement services for the patient's surviving family members for at least one year after the patient's death
- Social services/counseling services, including spiritual services, to help the patient and his or her family reduce stress and problems, maximize positive aspects and provide opportunities for growth
- Appropriate community resources and dietary counseling are provided as needed
- Medical direction/consultation by a physician with the interdisciplinary team and the patient's attending physician with regard to pain and symptom management (This physician also will act as a liaison with other physicians in the community.)
- Volunteer services provided by trained hospice volunteers to provide support and companionship to the patient and his or her family during the remaining days of the patient's life and to the patient's family after his or her death
- Short-term inpatient care
- Prescription drugs and durable medical equipment and supplies, to the extent reasonable and necessary for the palliation and management of the terminal disease or illness and related conditions
- Physical therapy, occupational therapy, and speech language pathology services for symptom control or to allow the patient to maintain activities of daily living and basic functional skills

Anthem will make hospice services available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of the terminal illness or disease and related conditions.

During a period of crisis, in which a patient requires continuous care to achieve palliation or management of acute medical symptoms, Anthem will:

- Make nursing care available on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain the patient at home
- Cover short-term inpatient care arrangements when the interdisciplinary team decides inpatient skilled nursing care is required that cannot be provided in the home
- Cover homemaker or home health aide services, or both, on a 24-hour basis, but the care provided during these periods must be predominantly nursing care

Anthem also will make respite care available. This means short-term inpatient care provided only when necessary to relieve the family members or other persons caring for the patient. Anthem will make respite care available only on an occasional basis and for no more than five consecutive days at a time.

Hospital services (coinsurance applies)

Anthem contracts with most hospitals in California. However, benefits are not provided for care given in the few hospitals without a contract with Anthem, except in a medical emergency. The Anthem Prudent Buyer provider listing has the hospitals that participate with us. In an emergency, you can go to any hospital without an OK from Anthem. All other inpatient hospital services, and some outpatient care,

require an OK from us. You do not need an OK from Anthem for childbirth, a mastectomy or reconstructive surgery related to a mastectomy.

Hospital services – Inpatient (coinsurance applies)

Requires Prior Authorization

Inpatient services must be those regularly provided and billed by a hospital.

The following inpatient hospital services are covered:

- A semi-private hospital room, including customary furnishings and equipment, or a private room when medically necessary
- Care in special units
- Operating rooms, delivery rooms, and special treatment rooms
- Supplies and services such as laboratory, cardiology, pathology, and radiology
- Diagnostic laboratory and X-ray services
- Drugs and medicines the hospital gives you during your stay, including oxygen
- Blood transfusions, including blood products
- Radiation therapy, chemotherapy, and dialysis treatment
- Meals and special diets as medically necessary
- General nursing care and special duty nursing as medically necessary
- Biologicals, blood products, and anesthesia
- Respiratory therapy, physical therapy, occupational therapy, speech therapy, and other diagnostic, therapeutic, and rehabilitative services as appropriate
- Inpatient care in connection with dental procedures when hospitalization is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure
- General anesthesia and associated facility charges in connection with dental procedures when hospitalization is necessary because of an underlying medical condition or clinical status or because of the severity of the dental procedure (only available to members younger than 7 years of age; the developmentally disabled, regardless of age; and members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age)
- Coordination of discharge planning, including the planning of such continuing care as may be necessary
- Artificial limbs or eyes
- Surgical implants for pacemakers and hardware for fixing fractures

Benefits are not covered when provided in a non-contracting hospital within California, except in a medical emergency.

Hospital services – outpatient (coinsurance applies)

Requires prior authorization for some services

The following outpatient hospital services are covered:

- Use of the emergency room
- Operating rooms and treatment rooms
- All surgeries in an ambulatory surgical center
- Hospital services that can reasonably be provided on an ambulatory basis, including related supplies and services such as laboratory, cardiology, pathology, and radiology
- Drugs and medicines the hospital gives you during your stay, including oxygen
- Blood transfusions, including blood products
- Services in conjunction with dental procedures when the use of a hospital or outpatient facility is required because of an underlying medical condition or clinical status or because of the severity of the
  dental procedure
- General anesthesia and associated facility charges, and outpatient services in connection with dental procedures when the use of a hospital or surgery center is necessary because of an underlying medical condition or clinical status or because of the severity of the dental procedure (only available to members younger than 7 years of age; the developmentally disabled, regardless of age; and members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age)
- Radiation therapy, chemotherapy, dialysis treatment, and blood transfusions
- Dressings, casts and use of cast room, anesthesia, and oxygen services when medically necessary

Benefits are not covered when provided in a non-contracting hospital or non-contracting dialysis treatment center in California, except in a medical emergency.

Infusion therapy (coinsurance applies)

Requires prior authorization

If services are performed in the home, those services must be billed and performed by a provider licensed under state and local laws.

A course of therapy is defined as physician-prescribed infusion therapy authorized under pre-service review by Anthem for a period of 90 days or less.

The following therapy may be provided if medically necessary:

- Drugs and other substances used in infusion therapy
- Professional services to order, prepare, dispense, deliver, administer, or monitor (including clinical pharmacy support) any drugs or other substances used in a course of therapy
- All necessary durable and reusable supplies and durable medical equipment including, but not limited to, pumps, poles, and electric monitors

Covered services will not include compounding fees (charges for mixing or diluting drugs, medicines, or solutions) or incidental supplies (disposable items, such as cotton swabs, tubing, syringes and needles for drugs, bandages, and intravenous starter kits) when furnished by a nonparticipating provider.

These services and supplies are covered when furnished by a participating provider, but no separate benefits will be paid for those services or supplies because their cost is included in the participating

provider's charges for drugs and other covered services. Medical supplies or equipment used in infusion therapy is not reimbursed under any other benefit of this plan.

Mental healthcare services – inpatient (coinsurance applies)

The following mental healthcare services are covered when provided in a participating hospital and when ordered and performed by a participating mental health professional.

Mental healthcare services

- Services for illnesses that do not meet the criteria for severe mental illness (SMI) or serious emotional disturbance (SED)

Limitations:

10 days per calendar year

Severe Mental Illness (SMI)

Inpatient mental healthcare services for the treatment of severe mental illnesses. SMI includes:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Limitations:

Unlimited days

Serious Emotional Disturbance (SED)

Limitations:

Unlimited days

Mental healthcare services – Outpatient (coinsurance applies)

Mental healthcare services when ordered and performed by a participating mental health provider.

Mental healthcare services

- Services for illnesses that do not meet the criteria for severe mental illness (SMI) or serious emotional disturbance (SED)
- Diagnosis and treatment of a mental health condition

Limitations:

15 visits per calendar year

Severe Mental Illness (SMI)

Outpatient mental healthcare services for the treatment of severe mental illnesses. SMI includes:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Limitations:

Unlimited visits

Serious Emotional Disturbance (SED)

Outpatient mental healthcare services for the diagnosis and treatment of SED.

SED refers to any mental disorder (in a child under age 18) that severely disrupts social, academic, and emotional functioning. A child is considered to have SED if his or her inappropriate behavior does not result from drug or alcohol substance abuse or a developmental disorder.

To determine if a child has SED, he or she must meet one or more of the following criteria:

1. Has substantial difficulties in at least two of the following areas: self-care, school functioning, family relationships, or the ability to function in the community, and either of the following occurs:
    i. The child is at risk of removal from the home or has already been removed; or
    ii. The mental health condition has been present for more than six months or is likely to continue for more than one year if not treated.
2. Shows signs of psychotic behavior, risk of suicide, or risk of violence which are related to the mental disorder
3. Meets special education eligibility requirements not related to developmental disorders

Limitations:

Unlimited visits

Orthotics and prosthetics (coinsurance applies)

We cover medically necessary original and replacement prosthetic and orthotic devices as prescribed by a licensed practitioner (physician, surgeon, podiatrist, or chiropodist) acting within the scope of his or her licensure.

We cover the following orthotics and prosthetics services:

- Installation accessories to restore a method of speaking related to a laryngectomy
- Therapeutic footwear for diabetes including podiatric devices such as foot orthotics, foot pads, and foot inserts
- Therapeutic footwear for members with foot disfigurement caused by (including, but not limited to) cerebral palsy, arthritis, polio, spina bifida, or diabetes
- Therapeutic footwear including medically necessary podiatric devices such as foot orthotics, foot pads, and foot inserts for members with foot disfigurement caused by an accident or developmental disability
- Orthotic devices such as a back brace and/or support, braces, and casts
- Prosthetic devices to restore and achieve symmetry after a mastectomy (including, but not limited to lumpectomy)

We do not cover non-rigid devices such as elastic knee supports, corsets, elastic stockings, or garter belts; dental appliances; electronic voice producing machines or more than one device for the same part of the body. We also do not cover eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

Physical, occupational, and speech therapy (coinsurance applies)

We cover medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as medically appropriate on an outpatient basis.

Pregnancy and maternity care (coinsurance applies)

Note: This covered benefit description for pregnancy care does not apply to the annual deductible.

Coverage information:

- Your newborn infant will be covered under the mother's benefit during the time the mother remains in the hospital following a routine delivery; 48 hours for a vaginal delivery, 96 hours for a cesarean section. **Your newborn infant will not be covered after this time.**
- Your newborn infant will not be covered if you have exhausted your annual maximum benefit.
- You may enroll your newborn in the MRMIP by contacting the MRMIP Enrollment Unit at **800-289-6574** within 60 days of the infant's birth.
- If your newborn infant requires a medically necessary hospitalization during the first 60 days of life, we will cover the newborn infant only if you have enrolled the newborn infant with MRMIP. We will not cover the hospitalization if you do not enroll the newborn infant with the

MRMIP prior to the expiration of the 60-day period.

We cover the following pregnancy and maternity care services:

- The services of a physician, surgeon, certified nurse-midwife, or nurse practitioner
- Doctor visits and all medically necessary professional services for pregnancy including prenatal, postnatal, and complications of pregnancy
- Prenatal testing known as the expanded alpha-fetoprotein program administered by the California Department of Public Health
- Hospital services
- Newborn examinations and nursery care while the mother is hospitalized, including newborn hospital visits and phenylketonuria (PKU) testing
- Normal childbirth and cesarean sections
- Complications of pregnancy
- Genetic testing before your baby is born
- Circumcision following birth and upon parent's request when performed by a healthcare provider

The mother and her newborn infant are entitled to inpatient hospital coverage for a period of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by Cesarean section. The decision to discharge the mother and newborn before the 48- or 96-hour time period can be made only by the treating physician in consultation with the mother. If the mother is discharged early, then the mother and newborn infant will be covered for a post discharge follow-up visit within 48 hours of the discharge when prescribed by the treating physician.

Prescription drugs (copayment or coinsurance applies)

Covered prescriptions include:

- Prescriptions and dental prescriptions ordered by a doctor because they are medically necessary
- Prenatal vitamins and vitamins with fluoride
- Insulin and insulin syringes
- Glucagon
- Lancets and test strips for use in monitoring diabetes
- Oral contraceptive drugs prescribed for birth control (If your physician determines that oral contraceptive drugs are not medically appropriate, coverage for another contraceptive method approved by the FDA will be provided, with our prior authorization.)
- Emergency contraception
- Formulas and special food products prescribed by a physician or nurse practitioner for the treatment of phenylketonuria (PKU)
- Formulas and special food products not covered under your prescription benefits are covered under your medical benefits
- Self-injectable medications as well as needles and syringes needed to administer them
- Office-based injectable medications, needles, and syringes not covered under your prescription benefits are covered under your medical benefits
- All non-infused, compound prescriptions that contain at least one covered prescription ingredient

Treatment of impotence and/or sexual dysfunction must be medically necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to Anthem for review. Drugs and medications for treatment of impotence and/or sexual dysfunction are limited to six tablets/units per 30-day period (not covered under the mail-order program).

Preventive care (coinsurance applies)

Note: This covered benefit description for preventive care does not apply to the annual deductible.

We cover comprehensive preventive care for adults and children. The comprehensive preventive care of children is consistent with the most current version of the *Recommendations for Preventive Pediatric Health Care* as adopted by the American Academy of Pediatrics and the most current version of the *Recommended Childhood Immunization Schedule/United States*, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Comprehensive preventive care services for adults and children include immunizations as well as periodic health evaluations and laboratory services in connection with them.

We cover the following preventive healthcare services when given under a physician's supervision (This includes services for the detection of asymptomatic diseases.):

- Breast exams and mammograms
- Pap smears, pelvic exams, and ovarian and cervical cancer screenings
- Human papillomavirus (HPV) screening test
- Human immunodeficiency virus (HIV) testing
- Prostate exams for men
- A variety of voluntary family planning services
- Newborn blood tests
- Prenatal care (care during pregnancy)
- Well-baby and well-child visits
- Vision and hearing tests for children
- Immunizations for children consistent with the most current version of the Recommended Childhood Immunization Schedule/United States jointly adopted by the American Academy of Pediatrics, the American Academy of Family Physicians, the Centers for Disease Control and Prevention (CDC), and the Advisory Committee on Immunization Practices (ACIP). This will include immunizations needed for travel as recommended by the ACIP.
- Immunizations for adults as recommended by the U.S. Department of Health and Human Services, the CDC, and the ACIP This will include immunizations needed for travel as recommended by the ACIP.
- Sexually transmitted disease (STD) testing
- Cytology examinations
- Health education including information on personal health behavior and healthcare, as well as recommendations about the optional use of healthcare services provided by Anthem or healthcare organizations affiliated with us
- Disease management programs for asthma, diabetes, cardiovascular, and prenatal

Limitations

The frequency of periodic health examinations will not be increased for reasons which are unrelated to the member's medical needs, including a member's desire for additional physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance or a school sports clearance.

Professional services – physician office visit (copayment or coinsurance applies)

We cover the following professional services:

- Services of a physician, in-person basis or via telehealth, if available
- Services within the scope of licensure of an anesthetist, a physician assistant, a nurse practitioner, or other advanced practice nurse
- Outpatient diagnostic radiology and laboratory services not in connection with preventive care services (These services are subject to the annual deductible.)
- Office visits for health problems or injuries (This includes allergy tests and treatments, respiratory care for breathing problems, and other specialist visits.)
- Mammograms when ordered by your physician registered nurse practitioner or certified nurse-midwife not in connection with preventive care services (These services are subject to the annual deductible.)
- Prostate-specific antigen (PSA) study and the office visit associated with performing that exam when ordered by your physician not in connection with preventive care services (These services are subject to the annual deductible.)
- Cytology exams on a reasonable periodic basis not in connection with preventive care services (These services are subject to the annual deductible.)
- Surgery, assistant surgery, and anesthesia (inpatient and outpatient)
  - This includes reconstructive surgery, unless a better option exists or the surgery would make only a small improvement.
  - These services require prior authorization for inpatient hospital care (except for childbirth, mastectomy or reconstructive surgery secondary to mastectomy).
- Radiation therapy, chemotherapy, dialysis treatment, and blood transfusions
- Inpatient professional services provided in a licensed hospital, hospice, or mental health facility
- Genetic testing and diagnostic procedures to treat an inheritable disease
- Drugs and medicines the doctor gives you during your visit
- Breast, cervical, and ovarian cancer screenings and the office visits associated with performing those tests when ordered by your physician, registered nurse practitioner, or certified nurse-midwife (These services are subject to the annual deductible.)
  - Cervical cancer screenings include the new HPV test when not in connection with preventive care services.
  - With a referral from your doctor, registered nurse practitioner, or certified nurse-midwife you may get any other cervical cancer screening approved by the FDA, such as the Pap smear test.

Telehealth services

Telehealth is a way of getting services without being in the same physical location as your provider. Telehealth may involve having a live conversation with your provider. Or telehealth may involve

sharing information with your provider without a live conversation. You can receive many services through telehealth. However, telehealth may not be available for all covered services. You can contact your provider to learn which types of services may be available through telehealth. It is important that both you and your provider agree that the use of telehealth for a particular service is appropriate for you. You have the right to in-person services and are not required to use telehealth even if your provider agrees that it is appropriate for you.

Third-party Corporate Telehealth Provider

A "Third-party corporate telehealth provider" is defined as a corporation directly contracted with a plan that provides health care services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services.

You have the availability of receiving the service on an in-person basis or via telehealth, if available, from your primary care provider, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards.

When accessing services through a third-party corporate telehealth provider, the following apply;

a. you have the right to access your medical records;
b. that the record of any services provided to you through a third-party corporate telehealth provider shall be shared with their primary care provider, unless the enrollee objects; and
c. that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and the cost-sharing will accrue to any applicable deductible or out-of-pocket maximum.

If you have coverage for out-of-network benefits, a reminder of the availability of receiving the service either via telehealth or on an in-person basis using your out-of-network benefits, and the cost-sharing obligation for out-of-network benefits compared to in-network benefits and balance billing protections for services received from contracted providers.

If you are currently receiving specialty telehealth services for a mental or behavioral health condition, you have the option to continue receiving specialty telehealth services for a mental or behavioral health condition with that contracting individual health professional, contracting clinic, or contracting facility, rather than to receive services via the third party telehealth provider.

Anthem requires providers to obtain consent from you for services provided by third-party corporate telehealth providers.

Providers outside of California – Blue Card program (copayment or coinsurance applies)

The Blue Cross and Blue Shield Association, of which Anthem is a member and independent licensee, administers a program called the Blue Card program. This program allows our members to have the reciprocal use of participating providers contracted with other Blue Cross and/or Blue Shield plans. If you have any questions or complaints about the Blue Card program, please call our toll-free Customer Care Center or TTY phone number.

Customer Care Center:	**877-687-0549**
TTY:	**888-757-6034**
24/7 NurseLine:	**800-224-0336**
TTY:	**711**

TTY lines are for members with hearing or speech loss only.
anthem.com/ca/medi-cal

If you are traveling outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield participating provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate with a local Blue Cross and/or Blue Shield plan. In order for you to receive access to whatever reductions in out-of-pocket expenses may be available, we must abide by the Blue Card program rules as set by the Blue Cross and Blue Shield Association. When you obtain healthcare services through the Blue Card program outside of California, the amount you pay for covered services is calculated on the lower of the billed charges for your covered services or the negotiated price that the on-site Blue Cross and/or Blue Shield plan (Host Blue) passes on to us.

Often, the negotiated price will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your healthcare provider or with a group of specified healthcare providers. The negotiated price may also be billed charges reduced to reflect an average savings with your healthcare provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price also will be adjusted in the future to correct for overestimation or underestimation of past prices; however, the amount you pay is considered the final price. Statutes in a small number of states may require the Host Blue to use a basis for calculating subscriber liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state mandate subscriber liability calculation methods that differ from the usual Blue Card program method noted in the preceding paragraph or require a surcharge, we would then calculate your liability for any covered healthcare service in accordance with the applicable state statute in effect at the time you received your care.

There are several types of Blue Card program providers, including the following:

- **PPO providers** – These are primarily hospitals and physicians who participate in a Blue Card PPO network and have agreed to provide PPO members with healthcare services at a discounted rate that is generally lower than the rate charged by traditional providers.
- **Traditional providers** – These are providers who might not participate in a Blue Card PPO network, but have agreed to provide PPO members with healthcare services at discounted rates.
- **Nonparticipating providers** – These are providers who do not have a contract with their local Blue Cross and/or Blue Shield plan and have not accepted the Blue Card PPO or traditional provider negotiated rates. To locate a Blue Card PPO or traditional provider when outside of California, call **800-810-BLUE (2583)** or go to the Blue Card website at **bcbs.com** and select "Find a Doctor". When traveling outside the U.S., in cases of emergencies only, call **800-810-BLUE** to inquire about providers who may participate in the Blue Card worldwide program.

Reconstructive surgery (coinsurance applies)

Medically necessary reconstructive surgical services performed on abnormal structures of the body caused by gender dysphoria, congenital defects, developmental anomalies, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance to the extent possible. This benefit includes reconstructive surgery to restore and achieve symmetry incident to mastectomy

(including, but not limited to lumpectomy).

Reconstructive surgery also includes medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures or services.

Limitations

We do not cover cosmetic surgery to alter or reshape normal structures of the body to improve appearance.

Mastectomies, lymph node dissections, and lymphedema (coinsurance applies)

We cover the following services:

- Prosthetic devices or reconstructive surgery, including devices or surgery to restore and achieve symmetry, related to a mastectomy (including, but not limited to lumpectomy)
- All complications from a mastectomy, including lymphedema

We do not require prior authorization to determine the length of your hospital stay following a mastectomy or lymph node dissection.

Smoking cessation (coinsurance applies)

We will pay $50 per member per lifetime toward any smoking cessation program. Prescription drugs to aid smoking cessation, such as Nicorette or nicotine patches, are covered under your medical benefit.

Transplants (coinsurance applies)

Requires Prior Authorization

We cover the following transplant services:

- Human and nonhuman organ transplants (corneal, human heart, heart-lung, liver, and kidney) and bone marrow transplants, if medically necessary and not experimental or investigational in nature
  - If we do not cover a therapy because it is experimental or investigational and you are terminally ill, you may ask that another party review our decision.
  - We will arrange to have an impartial, independent entity review our decision in accordance with the requirements of California law.
  - If we determine that the requested service is not covered because it is investigational or prescribed for experimental indications, you may request an Independent Medical Review (IMR). To learn more about IMRs, see *Part 8: How to resolve a problem with Anthem.*
- Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to your transplant
- Charges to test your relatives for matching bone marrow transplants
- Charges associated with the search and testing of unrelated bone marrow donors through a

recognized donor transplant bank, if the expenses are directly related to your anticipated transplant

Transplants other than corneal shall be subject to the following restrictions:

- Pre-operative evaluation, surgery and follow-up care shall be provided at centers designated by Anthem as having documented skills, resources, commitment, and record of favorable outcomes to qualify the centers to provide such care
- Patients shall be selected by the patient-selection committee of the designated centers and subject to prior authorization
- Only anti-rejection drugs, biological products, and other procedures that have been established as safe and effective, and no longer investigational, are covered

Part 5 Benefits summary

The following summarized benefits are provided by the Anthem PPO plan. Some services are subject to limitations and/or prior authorization. This symbol indicates that prior authorization is required. All services are allowed only when medically necessary. For specific benefits, see *Part 4: What Anthem covers.*

Type of service	Description	Member pays to participating provider	Member pays to nonparticipating provider
Calendar year deductible	Amount due and payable within a calendar year for certain member services before we cover those services at the copayment or coinsurance amount	• $500 per member (subscriber only) • $500 per family (subscriber plus one or more dependents on the same policy)	• $500 per member (subscriber only) • $500 per family (subscriber plus one or more dependents on the same policy)
Copayment or coinsurance	Member's amount due and payable to the provider of care	See below	See below
Yearly maximum copayment/coinsurance limit	Member's annual maximum copayment/coinsurance limit when using participating providers in one calendar year (If nonparticipating providers are used, coinsurance and billed charges that exceed the customary and reasonable charges are the member's responsibility and do not apply to the yearly maximum copayment/coinsurance limit.)	• $2,500 per member (subscriber only) • $4,000 per family (subscriber plus one or more dependents on the same policy)	No yearly maximum copayment/coinsurance limit for nonparticipating providers; you pay unlimited coinsurance
Annual benefit maximum	$75,000 of covered expenses per calendar year per member	You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $75,000 in one calendar year per member	You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $75,000 in one calendar year per member
Lifetime benefit maximum	$750,000 of covered benefits per lifetime of each member	You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $750,000 in a lifetime per member	You must pay for all services received after the combined total of all benefits paid under the MRMIP reaches $750,000 in a lifetime per member

Type of service	Description	Member pays to participating provider	Member pays to nonparticipating provider
Alcohol and drug abuse – Inpatient ***Requires Prior Authorization***	Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the body	15% of negotiated fee rate	15% of customary and reasonable charges plus any charges in excess
Ambulance services	Ground or air ambulance to or from a hospital for medically necessary services	15% of negotiated fee rate	15% of customary and reasonable charges plus any charges in excess
Blood and blood products	Processing, storage, and administration of blood and blood products in inpatient and outpatient settings	15% of negotiated fee rate	50% of customary and reasonable charges plus any charges in excess
Cataract spectacles and lenses	Limited to one pair of conventional eyeglasses or conventional contact lenses if necessary after cataract surgery	15% of negotiated fee rate	50% of customary and reasonable charges plus any charges in excess
Dental injury treatment	Accidental injury to natural teeth or jaw	15% of negotiated fee rate	50% of customary and reasonable charges plus any charges in excess
Diabetes treatment	Diabetes self-management training provided to members with diabetes	15% of negotiated fee rate	50% of customary and reasonable charges plus any charges in excess
Diagnostic X-ray and laboratory services ***Requires Prior Authorization for Certain Services***	Outpatient diagnostic X-ray and laboratory services (CT, MRI, MRA, PET, and SPECT require prior authorization with the exception of services performed as part of an emergency.)	15% of negotiated fee rate	50% of customary and reasonable charges plus any charges in excess
Durable Medical Equipment and supplies ***Requires Prior Authorization for Certain Services***	Medical equipment and supplies required to care for an illness or injury (Formulas and special food products require prior authorization.)	15% of negotiated fee rate	50% of customary and reasonable charges plus any charges in excess

Type of service	Description	Member pays to participating provider	Member pays to nonparticipating provider
Emergency healthcare services	Initial treatment of an acute, serious illness or accidental injury; includes hospital, professional, and supplies (Services for nonemergencies in an emergency or urgent care setting are not covered.) Emergency services are covered both in and out of the plan's service area and in the plan's participating or any non-participating facilities.	15% of negotiated fee rate for hospital and professional services and ambulatory surgical center services	• 15% of customary and reasonable charges or billed charges, whichever is less plus any charges in excess of customary and reasonable for the first 48 hours for hospital and professional services (If the member's medical condition prohibits transfer to a participating facility after 48 hours, the member's copayment will remain at 15% of customary and reasonable charges or billed charges, whichever is less, plus any charges in excess of customary and reasonable until his or her medical condition permits transfer to a participating facility. If the member is stable but remains in a non-contracting facility beyond 48 hours, the member pays all charges; no benefits are provided.) • 15% customary and reasonable charges plus any charges in excess for ambulatory surgical center

Type of service	Description	Member pays to participating provider	Member pays to nonparticipating provider
Emergency healthcare services	Initial treatment of an acute, serious illness or accidental injury; includes hospital, professional and supplies (Services for nonemergencies in an emergency or urgent care setting are not covered.) Emergency services are covered both in and out of the plan's service area and in the plan's participating or any non-participating facilities.	15% of negotiated fee rate for hospital and professional services and ambulatory surgical center services	• 15% of customary and reasonable charges or billed charges, whichever is less plus any charges in excess of customary and reasonable for the first 48 hours for hospital and professional services (If the member's medical condition prohibits transfer to a participating facility after 48 hours, the member's copayment will remain at 15% of customary and reasonable charges or billed charges, whichever is less, plus any charges in excess of customary and reasonable until his or her medical condition permits transfer to a participating facility. If the member is stable but remains in a non-contracting facility beyond 48 hours, the member pays all charges; no benefits are provided.) • 15% customary and reasonable charges plus any charges in excess for ambulatory surgical center
Family planning services (This service does not apply to the annual deductible.)	• Prescription contraception methods approved by the FDA • Emergency contraception • Sterilization, including tubal ligation and vasectomy	15% of negotiated fee rate	50% of customary and reasonable charges plus any charges in excess
Foreign country providers	Limited to initial treatment of a medical emergency only	There are no participating providers out of the country	• 15% of customary and reasonable charges plus any charges in excess for hospital services • 15% of customary and reasonable charges plus any in charges excess for professional services

Type of service	Description	Member pays to participating provider	Member pays to nonparticipating provider
Home healthcare ***Requires Prior Authorization***	Home health services through a home health agency or visiting nurses association	15% of negotiated fee rate	50% of customary and reasonable charges plus any charges in excess
Hospice ***Requires Prior Authorization***	Hospice care for members who are not expected to live for more than 12 months if the disease follows its natural course	15% of negotiated fee rate	50% of customary and reasonable charges plus any charges in excess
Hospital services – Inpatient ***Requires Prior Authorization*** **(No prior authorization is required for childbirth, mastectomy, or reconstructive surgery after a mastectomy.)**	Services regularly provided and billed by a hospital	15% of negotiated fee rate for inpatient hospital services and professional services	• All charges except $650 per day for inpatient hospital services • 50% of customary and reasonable charges plus any charges in excess for professional services (No benefits are provided in a non-contracting hospital in California, except in the case of a medical emergency.)
Hospital services – Outpatient ***Requires Prior Authorization for Certain Services***	Outpatient services; ambulatory surgical centers	15% of negotiated fee rate for outpatient hospital services and professional services	• All charges except $380 per day for outpatient hospital services and ambulatory surgical center services • 50% of customary and reasonable charges plus any charges in excess for professional services • All charges except $380 per day for non-contracting ambulatory surgical center services (No benefits are provided in a non-contracting hospital or non-contracting dialysis treatment center in California, except in the case of a medical emergency.)

Type of service	Description	Member pays to participating provider	Member pays to nonparticipating provider
Infusion therapy ***Requires Prior Authorization***	Therapeutic use of drugs or other substances ordered by a physician and administered by a qualified provider	15% of negotiated fee rate	• Member pays all charges in excess of $500 per day for all infusion therapy and related administrative and professional services • Member pays all charges in excess of the average wholesale price for all infusion therapy drugs and any charges in excess of the maximum per day indicated below
Mental healthcare services (Inpatient)	Mental healthcare in a participating hospital when ordered and performed by a participating mental health professional for the treatment of a mental health condition	15% of negotiated fee rate and all costs for stays over 10 days for inpatient hospital services or inpatient professional services	• All charges except for $175 per day up to 10 days. In addition, all costs for stays over 10 days for inpatient hospital services; 50% of customary and reasonable charges plus any charges in excess up to 10 days and all costs over 10 days for inpatient professional services.
Mental healthcare services	• Services for illnesses that do not meet the criteria for Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED) • Diagnosis and treatment of a mental health condition • 10 days per calendar year		
Severe Mental Illness (SMI)	• Inpatient mental healthcare services for the treatment of severe mental illness • Unlimited days	• SMI and SED of a child — 15% of negotiated fee rate for inpatient and outpatient hospital services	• SMI and SED of a child — All charges except for $650 per day for inpatient hospital services; 50% of customary and reasonable charges plus any charges in excess for inpatient professional services

Type of service	Description	Member pays to participating provider	Member pays to nonparticipating provider
Serious Emotional Disturbance (SED) services	• Inpatient mental healthcare services for the treatment for SED condition • Unlimited days	SMI and SED of a child — 15% of negotiated fee rate for inpatient and outpatient hospital services	• SMI and SED of a child — All charges except for $650 per day for inpatient hospital services; 50% of customary and reasonable charges plus any charges in excess for inpatient professional services
Mental healthcare services (Outpatient)	Mental healthcare when ordered and performed by a participating mental health professional	15% of negotiated fee rate for 15 visits per year and all costs for more than 15 visits for outpatient hospital services or outpatient professional services	• All charges except $380 per day and all costs over 15 visits for outpatient hospital services; 50% of customary and reasonable charges plus any charges in excess. In addition, all costs over 15 visits for professional services.
Mental healthcare services	• Services for illnesses that do not meet the criteria for Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED) • 15 visits per calendar year		
Severe Mental Illness	• Outpatient mental healthcare visits for treatment of severe mental illnesses • Unlimited visits	SMI and SED of a child – 15% of negotiated fee rate for inpatient and outpatient hospital services and professional services; $25 for professional services received in the provider's office	• SMI and SED of a child – All charges except for $380 per day for outpatient hospital services; 50% of customary and reasonable charges plus any charges in excess for outpatient professional services
Serious Emotional Disturbance (SED) services	• Outpatient mental healthcare visits for the treatment of SED conditions. • Unlimited visits	SMI and SED of a child – 15% of negotiated fee rate for inpatient and outpatient hospital services and professional services; $25 for professional services received in the provider's office	• SMI and SED of a child – All charges except for $380 per day for outpatient hospital services; 50% of customary and reasonable charges plus any charges in excess for outpatient professional services

Type of service	Description	Member pays to participating provider	Member pays to nonparticipating provider
Orthotics and prosthetics	Special footwear for foot disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, an accident, or a developmental disability	15% of negotiated fee rate	50% of customary and reasonable charges plus any charges in excess
Physical, Occupational and Speech Therapy	Services of physical, occupational, and speech therapists as medically appropriate on an outpatient basis	15% of negotiated fee rate	You pay all charges except $25 per visit
Pregnancy and maternity care (The covered benefit description for pregnancy care does not apply to the annual deductible.)	• Inpatient normal delivery • Complications from pregnancy • Prenatal and postnatal care	• 15% of negotiated fee rate for hospital services • 15% of negotiated fee rate for professional services	• All charges except $650 per day for hospital services • 50% of customary and reasonable charges plus any charges in excess for professional services
Prescription drugs	• Maximum 30-day supply for prescriptions when filled at a retail pharmacy • Maximum 60-day supply for mail-order prescriptions filled through CarelonRx	• $5 for generic drugs • $15 for brand-name drugs • $5 for generic drugs through mail-order home delivery prescription drug program (CarelonRx) • $15 for brand-name drugs through mail-order home delivery prescription drug program (CarelonRx)	• All charges except 50% of drug limited fee schedule for generic or brand-name drugs • Mail-order prescription drug service is not available through nonparticipating provider

Type of service	Description	Member pays to participating provider	Member pays to nonparticipating provider
Preventive care services (These services are covered even if you have not met the calendar year deductible. These services do not apply towards the annual deductible.)	• Breast exams • Pelvic exams • Pap smears • Ovarian and cervical cancer screenings • Mammograms • Human papillomavirus (HPV) screening test • Cytology exams • Family planning • Health education • Periodic health exams and laboratory services in connection with them • Hearing and vision exams for children • Newborn blood tests • Prenatal care (care during pregnancy) • Prostate exams for men • Sexually transmitted disease (STD) testing • Human immunodeficiency virus (HIV) testing • Well-baby and well-child visits • Certain immunizations for children and adults, including immunizations needed for travel • Disease management programs for asthma, diabetes, cardiovascular, and prenatal	15% of negotiated fee rate	50% of customary and reasonable charges plus any charges in excess
Professional services	Services of a physician for medically necessary services	$25 office visit; 15% of negotiated fee rate for other services	50% of customary and reasonable charges plus any charges in excess

Type of service	Description	Member pays to participating provider	Member pays to nonparticipating provider
Providers outside of California – Blue Card program ***Requires Prior Authorization for Certain Services***	The Blue Cross and Blue Shield Association, of which Anthem is a member and independent licensee, administers a program called the Blue Card program. We participate in this program, which allows members to have reciprocal use of participating providers contracted with other Blue Cross and/or Blue Shield plans. Blue Card provider types are PPO and traditional. Nonparticipating providers may be used outside of California.	• Nonmedical emergencies – 15% of the Blue Card provider's negotiated price for PPO providers; 50% of the Blue Card provider's negotiated price for Traditional providers for hospital services • Medical emergencies – 15% of the Blue Card provider's negotiated price for PPO providers; 15% of the Blue Card provider's negotiated price for Traditional providers for hospital services • Nonmedical emergencies – 15% of the Blue Card provider's negotiated price for PPO providers; 50% of the Blue Card provider's negotiated price for traditional providers for professional services • Medical emergencies – 15% of the Blue Card provider's negotiated price for PPO providers; 15% of the Blue Card provider's negotiated price for Traditional providers for professional services	• Nonmedical emergencies – all charges except for $650 per day for nonparticipating providers for hospital services; all charges except for $380 per day for nonparticipating providers for ambulatory surgical centers services • Medical emergencies – 15% of customary and reasonable charges plus charges in excess for nonparticipating providers for first 48 hours; after 48 hours, all charges in excess of $650 per day for hospital services (If the member's medical condition prohibits transfer to a PPO or traditional facility after 48 hours, the member's copayment remains at 15% of customary and reasonable charges plus any charges in excess until his/her condition allows transfer to a PPO or Traditional facility.) • Nonmedical emergencies – 50% of customary and reasonable charges plus charges in excess for nonparticipating providers for professional services • Nonmedical emergencies — 15% of customary and reasonable charges and any in excess for nonparticipating providers for professional services

Type of service	Description	Member pays to participating provider	Member pays to nonparticipating provider
Reconstructive surgery (No prior authorization is required if the reconstructive surgery is related to a mastectomy.)	Reconstructive surgery to improve function or to create a normal appearance (to the extent possible) for abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. Includes medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures or services.	• 15% of negotiated fee rate for hospital services • 15% of negotiated fee rate for professional services	• All charges except for $650 per day for hospital services • 50% of customary and reasonable charges plus any charges in excess for professional services
Skilled nursing facilities ***Requires Prior Authorization***	Skilled nursing care	Not covered unless we recommend it as a medically appropriate more cost-effective alternative plan of treatment	Not covered unless we recommend it as a medically appropriate more cost-effective alternative plan of treatment
Smoking cessation	Any smoking cessation program to help a member stop smoking	All charges except for $50 per member per lifetime	All charges except for $50 per member per lifetime
Transplants ***Requires Prior Authorization***	Transplants of human and nonhuman organs or tissues	• 15% of negotiated fee rate for hospital services • 15% of negotiated fee rate for professional services	• All charges except for $650 per day for hospital services • 50% of customary and reasonable charges plus any charges in excess for professional services

Part 6 What Anthem does not cover

The services listed in this section are not covered under the Anthem plan.

If you have any questions about what is not covered, call our Customer Care Center or TTY phone number.

Dental care

- Braces or other appliances or services for straightening the teeth (orthodontic services)
- Dentures, bridges, crowns, caps, or other dental services, or treatment of the teeth or gums or having teeth pulled (except for care given if teeth are accidentally injured)
- Dental implants or implant removal
- Services or supplies for treatment of the jaw joint (including treatment for temporomandibular joint problems) or the way the upper and lower teeth meet (except when medically necessary)
- Services of the dentist or oral surgeon for dental procedures
- Damage to natural teeth caused by chewing or biting
- Hospital stays for the purpose of administering general anesthesia that are not considered medically necessary

Home healthcare

- Services from agencies other than a certified home health agency or visiting nurse association
- Services for personal care such as help in walking, bathing, dressing, feeding, or preparing food
- Custodial care

Hospital services

- No benefits are provided for care or treatment furnished in a non-contracting hospital, except for a medical emergency (This exclusion applies only in California.)
- Personal or comfort items, or a private room in a hospital, unless medically necessary
- Cosmetic surgery done to change or reshape normal body parts so that they look better
  - This does not apply to reconstructive surgery to improve function or create a normal appearance (to the extent possible) for abnormal structures of the body caused by gender dysphoria, congenital defects, developmental abnormalities, trauma, infection, tumors, or disease.
  - This also does not apply to prosthetic devices or reconstructive surgery including devices or surgery to restore and achieve symmetry related to a mastectomy.
- Standby physicians, even when required by the hospital, unless determined by us to be medically necessary
- Services provided by a skilled nursing facility or any institution that provides continuous skilled nursing services, unless we determine that there is no less costly alternative to provide medically necessary services

Infusion therapy

- Drugs or medicines not requiring a prescription
- Drugs labeled *caution: limited by federal law to investigational use* or drugs prescribed for experimental use
- Drugs or other substances obtained outside the U.S., unless related to a medical emergency
- Homeopathic medications or other herbal medications not approved by the FDA
- Charges by a nonparticipating provider exceeding the average wholesale price of a drug as determined by the manufacturer
  –The average wholesale price includes the preparation of the finished product.
  – The average wholesale price is the average of the list prices that the manufacturers producing the drug suggest that a wholesaler charge a pharmacy for the drug.
  – You will be responsible for any charges in excess of the average wholesale price of a drug for nonparticipating providers.

Medical equipment and supplies

- Educational supplies
- Items furnished primarily for your personal comfort or convenience, such as air conditioners, air filters, air purifiers, humidifiers, exercise equipment, treadmills, spas, swimming pools, elevators, or supplies for hygiene or beautification
- Disposable supplies, except ostomy bags
- Urinary catheters or supplies consistent with Medicare coverage guidelines
- Experimental, investigational, or research equipment
- More than one piece of equipment that serves the same function, except to the extent medically necessary
- Corrective shoes or shoe inserts, footwear, or arch supports (except for therapeutic footwear for diabetes)
- Non-rigid devices such as elastic knee supports, corsets, elastic stockings, or garter belts
- Dental appliances or orthodontic appliances
- Electronic voice-producing machines
- Any supplies furnished in connection with the diagnosis and treatment of infertility
- More than one device for the same part of the body
- Hearing aids or routine hearing tests, except hearing tests for children
- Surgical implants, except pacemakers; intraocular lenses; hardware for fixing fractures; or internal breast prostheses following a mastectomy, resulting from disease, illness, or injury

Mental health

- Learning disabilities, except for SMI and SED conditions (See *Part 4: What Anthem covers)*
- Substance abuse, chemical dependency, alcoholism, or drug addiction
- Detoxification for alcohol or substance abuse, except when medically necessary
- Facility charges for psychiatric day care centers, except for SMI and SED conditions (See *Part 4: What Anthem covers)*

Other services

- Any services which are received prior to your effective date of coverage
- Any amounts in excess of the maximum amounts stated in the benefit sections of this plan
- Any services or supplies that are not medically necessary
- Those medical, surgical (including implants) or other healthcare procedures, services, drugs, or devises that are either:
  – Experimental or investigational, or not recognized in accord with generally accepted medical standards as being safe and effective for the treatment in question
  – Outmoded or not effective

If we determine that the requested service, product, drug or device is not covered because it is investigational or prescribed for experimental indications, you may request an IMR (To learn more about IMRs, see *Part 8: How to resolve a problem with Anthem.)*

- Any service not OK'd by us when prior authorization is required (To learn more, see *Part 1: How to use your Anthem PPO health plan* under the heading *Prior authorization (an OK by Anthem).)*
- Consultations provided by telephone or fax machine
- Services not listed as being covered by your plan
- Services you receive outside of the MRMIP that you are not required to pay for or are given to you for free
- Care you receive for health problems that are work-related and are paid for under the workers' compensation law or a similar law (If such other coverage is available, we will provide benefits under this program subject to its right to a lien or other recovery under applicable law.)
- Services performed in emergency or urgent care settings for nonemergency or non-urgent conditions (You will be liable for all charges associated with these services.)
- Services you receive from local, state or federal government agencies that you are not legally required to pay for, except when federal or state law expressly requires us to pay for them (We will pay for services provided at U.S. Department of Veterans Affairs hospitals and military treatment facilities to the extent required by law.)
- Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests that could have been performed safely on an outpatient basis, except to the extent that room and board is medically necessary
- Transportation by airplane, passenger car, taxi, or other form of public transport
- Professional services provided in the home by a person who lives in the member's home or who is related to the member by blood, marriage, or adoption
- Inpatient or outpatient services of a private duty nurse
- Personal or comfort items or a private room in a hospital unless medically necessary
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy, rest cures, or treatment of chronic pain
- Services provided by a rest home, a home for the aged, a nursing home or any similar facility

Pregnancy and maternity care

- Surgery to reverse sterilization
- Fertility treatments, such as artificial insemination or in vitro fertilization
- Diagnosis and treatment of infertility
- Maternity care for a Paid Surrogate Mother who enrolled in the program with an effective date on or after February 1, 2012

Prescription drugs

- Nonmedicinal substances or items
- Drugs furnished by a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility
  - – You will want to know the following if you need prescription drugs in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility:
    - Under *Part 4: What Anthem covers*, drugs and medicines furnished to you while you are a patient at a hospital are covered as specified under the heading *Hospital services* subject to all terms that apply to those benefits.
    - Drugs and medicines furnished to you by a skilled nursing facility while you are a patient at a skilled nursing facility are covered only when we determine that the services provided by the skilled nursing facility are a less costly alternative to the basic minimum benefits. To learn more, see *Part 6: What Anthem does not cover* under the heading *Hospital services.*
    - In a skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility, drugs supplied and administered by your physician are explained in *Part 4: What Anthem covers* under the heading *Professional Services* subject to all terms that apply to those benefits. Other drugs that may be prescribed by a physician for you in a skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility can be purchased at a pharmacy by you, a friend, a relative or a caregiver on your behalf or through our mail-order program and, in such case, benefits will be provided under this prescription drug benefit.
- Any expenses incurred in excess of the drug limited fee schedule at a nonparticipating pharmacy
- Any drug labeled "caution, limited by federal law to investigational use" (Non-FDA approved investigational drugs or any drug or medication prescribed for experimental indications is not covered.) If we determine that the requested drug is not covered because it is investigational or prescribed for experimental indications, you may request an IMR. To learn more about IMRs, see *Part 8: How to resolve a problem with Anthem.*
- Durable medical equipment (DME), devices, appliances or supplies (While not covered under this prescription drug benefit, you will want to know that if you need these items, you can learn more about what we do cover in *Part 4: What Anthem covers***,** under the heading *Durable Medical Equipment and supplies* subject to all terms that apply to those benefits.) Professional charges in connection with administering, injecting, or dispensing of drugs or infusion medications (While not covered under this prescription drug benefit, these services are covered as specified in *Part 4: What Anthem covers*
- Drugs and medications dispensed or administered in an outpatient setting, including, but not

limited to, outpatient hospital facilities and doctors' offices (While not covered under this prescription drug benefit, you will want to know that if you need such drugs in an outpatient setting, you can learn more about what we cover in *Part 4: What Anthem covers*

- Drugs used for the primary purpose of treating infertility
- Allergy desensitization products and allergy serum (While not covered under this prescription drug benefit, if you need such drugs, you can learn more about what we cover in *Part 4: What Anthem covers*
- All infusion therapy except self-administered injectables and aerosols (While not covered under this prescription drug benefit, you can learn more about what we cover in *Part 4: What Anthem covers*
- Brand-name medications that have generic equivalents are not covered, unless a physician denotes medical necessity by writing "do not substitute" or "dispense as written" on the prescription order or by requesting prior authorization from Anthem Pharmacy Management by calling **800-700-2533** (Certain medications are not recommended to be interchanged once they have been started. These medications are called narrow therapeutic index (NTI) drugs. NTI drugs with available generic equivalents are covered under the prescription drug benefit without the physician denoting "do not substitute" or "dispense as written." A list of applicable NTI drugs is available on our website [**https://mss.anthem.com/california-medicaid/benefits/major-risk-medical-insurance-plan.html**] or by calling Anthem Pharmacy Management.)
- Syringes and/or needles, except those dispensed for use with insulin (While not covered under this prescription drug benefit, these items are covered as specified in *Part 4: What Anthem covers*
- Drugs prescribed for cosmetic purposes (for example, Retin-A for wrinkles)
- Drugs obtained outside of the U.S., unless related to a medical emergency
- Dietary supplements, herbs, vitamins, cosmetics, health or beauty aids or similar products which are not FDA-approved to treat, diagnose, prevent, or cure a medical condition
- You will want to know the following:
  – Formulas for the treatment of PKU are covered as specified in *Part 4: What Anthem covers*
  – Health aids that are medically necessary and satisfy the definition of DME are covered as specified in *Part 4: What Anthem covers*
- Drugs and medications used to induce non-spontaneous abortions (While not covered under this prescription drug benefit, FDA-approved medications that may only be dispensed except in cases where administered under direct supervision of, a physician such as drugs and medications used to induce
  non-spontaneous abortions, are covered as specified under *Part 4: What Anthem covers*
- Drugs or medications that may be obtained without a physician's prescription (over-the-counter medications), except insulin and niacin for cholesterol lowering
- Prescription drugs that have nonprescription chemical and dosage equivalents
- Pharmaceuticals to aid smoking cessation (for example, Nicorette or nicotine patches), over-the-counter remedies or any prescription product containing nicotine (While not covered under this prescription drug benefit, pharmaceuticals to aid smoking cessation are covered as specified in *Part 4: What Anthem covers*
- Contraceptive devices prescribed for birth control except as specifically stated in *Part 7: How to get prescription drugs* (Contraceptive implants and associated professional services are covered as

specified in *Part 4: What Anthem covers*
- Drugs used for weight loss except when medically necessary
- Treatment of impotence and/or sexual dysfunction must be medically necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to Anthem Pharmacy Management for review (Drugs and medications for treatment of impotence and/or sexual dysfunction are limited to six tablets/units per 30-day period. These services are not covered under the mail-order program.)
- Childhood immunizations, hepatitis B or varicella zoster (chickenpox) vaccines for members 16 years of age or younger (While not covered under this prescription drug benefit, these immunizing agents are covered as specified in *Part 4: What Anthem covers*

Professional services

- Routine physical exams for a job, school camp, or sports program
- Optometric services, eye exercises, and orthoptics, routine eye exams (except vision testing for children), routine eye refractions, eyeglasses, contact lenses (except the first lens following cataract surgery), and eye surgery just for correcting vision (like near-sightedness)
- Foot care like nail trimming except when medically necessary podiatric medical care
- Chiropractic services or treatment
- Acupuncture care or treatment
- Benefits which exceed $75,000 in a calendar year under the program for a subscriber, or a subscriber's enrolled dependent or a dependent subscriber
- Benefits which exceed $750,000 in a lifetime under the program for a subscriber, or a subscriber's enrolled dependent or a dependent subscriber (Benefits received prior to January 1, 1999, shall be counted towards the $750,000 lifetime maximum.)

Part 7 How to get prescription drugs

Benefits are provided as follows for prescription drugs purchased from licensed retail pharmacies or through our mail-order home delivery prescription drug program by members who are eligible to receive outpatient prescription drugs under this Combined Evidence of Coverage and Disclosure Form.

What can my doctor prescribe?

Anthem uses a chosen list of drugs called a formulary (drug list) to help your doctor decide which drugs to prescribe. A group of doctors and pharmacists updates this list of drugs every three months. Updating this list helps ensure that the drugs on it are safe and useful. If you would like to know if a drug is on this list, or if you want a copy of the formulary, please call Anthem Pharmacy Management administered by CarelonRx. Although a drug is on the list, your doctor will decide which drug is best for you.

Generic equivalents of brand-name medications will be dispensed by participating pharmacies unless the prescription states “dispense as written” or “do not substitute” or no generic equivalent exists. Some drugs require prior authorization of benefits or have restrictions based on medical necessity. Please call Anthem Pharmacy Management if you have a question about prior authorization of benefits. Generic drugs will be dispensed by participating pharmacies unless the prescription specifies a brand name and states “dispense as written” or “do not substitute” or no generic equivalent exists. We will review and decide upon requests for prior authorization of benefits within one business day or less based upon the nature of the member’s medical condition. A 72-hour emergency supply of medication may be dispensed to the member by the pharmacist if he or she determines it is appropriate. Anthem will pay the charges for that emergency supply except for the applicable copayment/coinsurance. If the request for prior authorization of benefits is denied, you will receive a letter of explanation with the reasons for disapproval and any alternative drug or treatment offered.

If you have a problem or a concern with services from Anthem, please call our Customer Care Center or TTY phone number. You can also file a grievance to get an answer to any problem or concern you are having with Anthem, including appealing the denial of a request for prior authorization of benefits. We can mail a grievance form to you to fill out and return. For additional information, see *Part 8: How to resolve a problem with Anthem.*

Anthem checks the medicines you are using. If we see that too many drugs are being used, we will let your doctor and your pharmacist know. Some drugs can be harmful if taken together.

For purposes of this benefit, insulin and prescription prenatal vitamins are considered prescription drugs.

Where to get your prescriptions filled

We recommend that you obtain your prescription drugs from an Anthem-participating pharmacy. You can locate an Anthem-participating pharmacy by calling drugstores located near you and asking them if they accept Anthem or by calling Anthem Pharmacy Management for participating pharmacies. You can also obtain prescription drugs at a participating or nonparticipating pharmacy, either inside or outside of California.

Call Anthem Pharmacy Management if you have any questions about your pharmacy benefits.

If you need an emergency supply of medication, go to the nearest drugstore and have them call us.

Prescription drugs

When you get your prescription filled at an Anthem-participating pharmacy, you will be given a 30-day supply of medicine. You may get refills if your doctor wrote your prescription with refills. Usually the pharmacy will call your doctor to check if refills can be given.

Covered prescriptions include:

- Prescriptions and dental prescriptions when a physician determines that they are medically necessary
- Prescription prenatal vitamins and vitamins with fluoride
- Insulin and insulin syringes
- Glucagon
- Lancets and lancet puncture devices
- Test strips for use in monitoring diabetes
- Prescription contraceptive drugs prescribed for birth control
  – If your physician determines that prescription contraceptive drugs are not medically appropriate, coverage for another FDA-approved contraceptive method will be provided through our prior authorization process.
- Emergency contraception
- Formulas and special food products prescribed by a physician or nurse practitioner to treat PKU
  – Formulas and special food products not covered under your prescription benefits will be covered under your medical benefits.
- Self-injectable medications and needles and syringes necessary for administering insulin medications
  – Office-based injectable medications and needles and syringes for other injectable medications are not covered under your prescription benefits and will be covered under your medical benefits.
- All non-infused compound prescriptions that contain at least one covered prescription ingredient
- Treatment of impotence and/or sexual dysfunction must be medically necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to Anthem Pharmacy Management for review
  – Drugs and medications for treatment of impotence and/or sexual dysfunction are limited to six tablets/units per 30-day period (not covered under mail-order program).

Conditions of service

The drug or medicine must:

- Be prescribed in writing by a physician and be dispensed within one year of being prescribed, subject to federal or state laws
- Be approved for use by the FDA

- Be for the direct care and treatment of the member's illness, injury, or condition – (Dietary supplements, health aids or drugs for cosmetic purposes are not included.)
- Be obtained from a licensed retail pharmacy, dispensed by a pharmacy, or ordered by mail through the mail-order program
- Not be used while the member is an inpatient in any facility. Other drugs that may be prescribed by a physician for you in a skilled nursing facility, rest home, sanatorium, convalescent hospital, or similar facility can be purchased at a pharmacy by you, a friend, a relative, or a caregiver on your behalf or through our mail-order program and, in such case, benefits will be provided under this prescription drug benefit

When your prescription is filled at a participating pharmacy:

- You will pay a copayment for each covered prescription and/or refill when you present your ID card
- You will be given a maximum of a 30-day supply per prescription
- Your participating pharmacy will collect your copayment and submit the charges to the Anthem prescription drug program electronically through an online electronic network

There are certain drugs that currently have potential equivalency issues. These drugs are called narrow therapeutic index (NTI) drugs. If you obtain an NTI drug from a participating pharmacy, even if a generic equivalent is available, you will be responsible for the brand name copayment. A list of applicable NTI drugs is available on our website (**https://mss.anthem.com/california-medicaid/benefits/major-risk-medical-insurance-plan/pharmacy-benefits.html**) or by calling Anthem Pharmacy Management.

When your prescription is filled at a nonparticipating pharmacy, you will have to pay for the full cost of the drug and submit a claim to:

CarelonRx
P.O. Box 52065
Phoenix, AZ 85072-2065

- You must bring a prescription claim form with you when your prescription is filled (nonparticipating pharmacies do not carry these forms). A portion of this claim form must be completed by the pharmacist filling your prescription. Mail the claim form with the appropriate portion completed and signed by the pharmacist to Anthem. For help with claim forms, call our Customer Care Center or TTY phone number.

Mail-order prescription drugs

Your mail service prescription drug program is administered by CarelonRx under contract with Anthem. Your mail-order home delivery prescription is filled by CarelonRx Home Delivery Service, a division of CarelonRx. Anthem does not dispense drugs or fill prescriptions.

When you get your prescription filled through a participating pharmacy, you will be given no more than a 30-day supply. You may get refills if your doctor wrote your prescription with refills. When you get your prescription filled through the mail-order prescription drug program, you will receive a 60-day supply.

Maintenance drugs

Maintenance drugs are drugs that are prescribed on a continual basis for chronic conditions such as arthritis, heart disease, diabetes, or high blood pressure.

Maintenance drugs may be obtained at Anthem-participating pharmacies or nonparticipating pharmacies. Maintenance drugs can also be obtained by mail through CarelonRx Home Delivery Service requiring only one copayment for a 60-day supply. The prescription must state the dosage, your name, and your address, and it must include your physician's signature.

The first mail-order prescription you submit must include a completed patient profile form:

- This form will be sent to you upon your enrollment in the program.
- Any subsequent mail-order prescription only needs to include the prescription and copayment.

Some prescription drugs and/or medicines are not available for purchase through the mail-order prescription drug program, including drugs not on the formulary (drug list); drugs and medications for the treatment of impotence and/or sexual dysfunction; injectables, except for insulin and antibiotics. Please check with the pharmacy Customer Care Center department for availability of the drug or medicine. For more information about your benefits or to get started with home delivery, you can go to **https://mss.anthem.com/california-medicaid/benefits/major-risk-medical-insurance-plan/pharmacy-benefits.html**, or call the Customer Care Center at the phone number on your member ID card. Members who are speech- or hearing-impaired should call TTY, 24 hours a day, seven days a week.

Part 8 How to resolve a problem with Anthem

If you are unhappy with Anthem or one of our providers, we would like to talk with you. Please call us to let us know why you are unhappy. Most problems can be solved over the phone. If you have a problem or concern, call Anthem as soon as possible.

Give us a chance to help you with any problems you are having with Anthem. If you need to write to us, use this address:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

If you have a problem or concern with services from Anthem or your healthcare provider, call one of our Anthem representatives at the toll-free Customer Care Center or TTY phone number.

You also can file a grievance to get an answer to any problem or concern that you are having with Anthem, a provider, or any element of the MRMIP. To file a grievance, please call us at **877-687-0549**. We can take your grievance over the phone, or we can mail a grievance form to you to fill out and return.

When you fill out this form, be sure to:

- Write in the numbers from your Anthem card.
- Tell us what happened or what you would like help with.

Mail the completed form to:

ATTN: Grievance Coordinator
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

If you need help translating your problem, concern, or grievance, call **877-687-0549**. When we receive your grievance, we will send you a letter within five days letting you know we are looking into your problem. After looking at the facts, we will send you a letter within 30 days to tell you what we decided or how we will solve the problem.

Appeals

If you are unhappy with a denial of service or payment, you can file an appeal. To file an appeal, call Anthem at **877-687-0549** or write us at:

ATTN: Grievance Coordinator
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Expedited plan review

If the problem involves an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, we will give you our response within three days. Call **877-687-0549** for an expedited plan review.

Department of Managed Health Care (DMHC)

If you are unhappy with the decision of your grievance, or if your grievance has not been resolved after at least 30 days, you may file your grievance with the California DMHC for review (see the heading *Other Help* in this section). You also may request voluntary mediation with Anthem before submitting a grievance to the DMHC. You may file a grievance with the DMHC after completing mediation or participating in Anthem's grievance process or voluntary mediation for 30 days. If your case involves an imminent threat to your health, you do not have to complete our grievance process or voluntary mediation or participate in either for at least 30 days, but you may submit your grievance immediately to the DMHC for review. An imminent threat to your health includes, but is not limited to, severe pain, potential loss of life, limb, or other major bodily function.

Independent Medical Review (IMR)

If Anthem decides to deny, modify or delay any services in whole or in part because they are not medically necessary, you may ask for a review of that decision. These services sometimes are called "disputed healthcare services."

If you file a complaint with Anthem about a disputed healthcare service and Anthem still decides to deny, modify, or delay the service, we must give you an IMR application. To ask for an IMR, you must file the application with the DMHC.

You do not have to pay an application fee or a processing fee of any kind. The DMHC will choose a medical review organization that is independent of Anthem to complete the review. You can provide information to support your request for an IMR. You can use the IMR process in addition to any other procedures or remedies that may be available to you. If you decide not to participate in the IMR process, you may forfeit any statutory right to pursue legal action against Anthem about the disputed healthcare service.

If you file an application with the DMHC, they will review it to confirm that:

- Your provider recommended a healthcare service as medically necessary; or you have received urgent care or emergency services that a provider determined were medically necessary; or you have been seen by an Anthem-participating provider for the diagnosis or treatment of the medical condition for which you seek IMR.
- Anthem denied, modified, or delayed the disputed healthcare service based in whole or in part on a decision that it was not medically necessary.
- You have filed a grievance with Anthem and either Anthem upheld the disputed decision or it remains unresolved after 30 days. If your grievance requires expedited review, you may bring it to the DMHC's attention immediately. The DMHC may waive the requirement that you follow

Anthem's grievance procedures in an extraordinary and compelling case.

You may apply for an IMR within six months of any of the occurrences listed above. The DMHC will choose an independent medical review organization (IMRO) to make the review through a provider or providers who are knowledgeable about the treatment of your medical condition. You will get a copy of the conclusions made in your case. If the IMRO decides the disputed healthcare service is medically necessary, Anthem will cover it.

The IMRO usually must make its decision within 30 days after it receives your application and supporting documents. If the case involves imminent and serious threat to your health, such as severe pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMRO must make its decision within three days. To learn more about the IMR process, or to ask for an application, please call Anthem at **877-687-0549**.

You also can ask for an IMR if Anthem denies coverage for a service because Anthem has decided it is experimental or investigational. Anthem will notify you in writing of the opportunity to request an IMR within five business days of the decision to deny coverage. If your doctor determines that the proposed therapy would be significantly less effective if not promptly initiated, the analysis and recommendations of the experts on the IMR panel will be rendered within seven days of a request for expedited review.

To request a review, call Anthem at **877-687-0549** or write to us at:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

To qualify for an IMR in this situation, all of the following conditions must be satisfied:

- You have a life-threatening or seriously debilitating condition.
  – A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted. It is also a condition or disease with a potentially fatal outcome where the end point of clinical intervention is survival.
  – A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- The proposed treatment must be recommended by a participating doctor, or a board-certified or board-eligible doctor, qualified to treat you, who has certified in writing that it is more likely to be beneficial than standard treatment, and who has provided the supporting evidence.
- If external independent review is requested by you or by a qualified nonparticipating doctor, as described above, the requester must supply two items of acceptable scientific support (as defined in this section).

Within five business days of the request by a qualified member for external independent review, we will give the reviewing panel all relevant medical records and documents for review, and any information submitted by the member or the member's physician. Any subsequent information received will be forwarded to the review panel within five business days. The IMRO will render an opinion within 30 days of the request (or seven days in the case of an expedited review), except the reviewer may ask for three more days if there was any delay in receiving the necessary records.

"Acceptable scientific support" includes the following sources:

- Peer-reviewed scientific studies published in medical journals with nationally recognized standards
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the Social Security Act
- The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information
- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS Database Health Services Technology Assessment Research
- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes
- Peer-reviewed abstracts accepted for presentation at major medical association meetings

Binding Arbitration

This Binding Arbitration provision does not apply to class actions.

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." YOU AND ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the member making a written demand on Anthem. The arbitration will be conducted by Judicial Arbitration and Mediation Services (JAMS), according to its applicable rules and procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be

conducted by another neutral arbitration entity, by agreement of the member and Anthem, or by order of the court, if the member and Anthem or Anthem Life and Health Insurance Company cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to whom the parties have agreed, in which cases, Anthem will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, California 90060-0007

DHCS appeals process

If you are unhappy with the resolution of your grievance, you can appeal to the California Department of Health Care Services (DHCS) at:

Department Of Health Care Services
MCOD - MS 4703 Major Risk Medical Insurance Program Appeal
P.O. Box 2769
Sacramento, CA 95812-2769

The appeal must be submitted to DHCS within 60 calendar days following Anthem's decision. The appeal must include the following:

- A copy of any decision being appealed or a written statement of the action or failure to act being appealed
- A statement specifically describing the issue you are disputing
- A statement of the resolution you are requesting
- Any other relevant information you would like to include

Appeals that do not include the above information will be returned. You may resubmit the complete appeal within 60 calendar days from Anthem's denial or within 20 calendar days of the receipt of the returned appeal, whichever is later.

Cultural and linguistic complaints

If you think that Anthem did not meet your cultural and linguistic needs, call Anthem at **877-687-0549** or write to us at:

ATTN: Grievance Coordinator
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

We can help you fill out a grievance form or mail a form to you to fill out.

Other help

The DMHC is responsible for regulating healthcare service plans. If you have a grievance against Anthem, you should first telephone Anthem at **877-687-0549** and use Anthem's grievance process before contacting the 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 Anthem, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an IMR. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by Anthem 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. DMHC also has a toll-free telephone number **888-HMO-2219**, and a TTY line **877-688-9891**, for members with hearing loss or speech impairment. The DMHC's website (**hmohelp.ca.gov**) has complaint forms, IMR applications forms and instructions online.

Part 9 Provisions of alternative benefits

In order for a member to obtain medically appropriate care in a more economical and cost-effective way, Anthem may recommend an alternative plan of treatment, which includes services not covered under this plan. Anthem makes treatment suggestions only; any decision regarding treatment belongs to the member and the member's physician. Benefits are provided for such an alternative treatment plan only on a case-by-case basis. Anthem has absolute discretion in deciding whether or not to offer a substitute benefit for any member, which alternative benefit may be offered, and the terms of the offer. Anthem's substitution of benefits in a particular case in no way commits Anthem to do so in another case or for another member. Also, it does not prevent Anthem from strictly applying the express benefits, limitations and exclusions of the plan at any other time or for any other member.

Benefits are provided only when all of the following criteria are satisfied:

- The member requires extensive long-term treatment
- Anthem anticipates that such treatment, utilizing services or supplies covered under the plan, will result in considerable cost
- A cost-benefit analysis by Anthem determines that the benefits payable under the plan for the alternative plan of treatment can be provided at a lower overall cost than the benefits the member would otherwise receive under the plan
- Alternative benefits paid are accumulated toward any annual or lifetime maximums under the plan
- The member agrees in writing to the alternative benefit

Part 10 Other things you may need to know

Advance Directive

You can file a form ahead of time to tell the doctor or other healthcare provider what to do, or not to do, if you are in danger of dying. This is called an *advance directive*.

Benefits are not transferable

You and your eligible family members are the only people entitled to receive benefits under this plan. The right to benefits cannot be transferred. Fraudulent use of such benefits may result in your disenrollment from Anthem and/or other appropriate legal action.

Conformity with law

Any provision of this plan, which, on the effective date, is in conflict with any applicable statute, regulation or other law, is hereby amended to conform with the minimum requirements of such law.

Expenses in excess of benefits

Neither Anthem nor the program is liable for any expenses the member may incur in excess of the benefits provided under this plan.

Form or content of EOC

No agent or employee of Anthem is authorized to change the terms, conditions, or benefits of this EOC.

Health Insurance Portability and Accountability Act (HIPAA)

If you lose your health insurance, you may have a legal right to continue health insurance coverage, although you would have to pay for the coverage yourself.

How we pay our providers

Anthem PPO pays doctors and healthcare providers on a fee-for-service basis. This means the doctors provide healthcare services to their patients then send a bill to Anthem for each of the services they give you. Anthem and these healthcare providers agree on how much is paid for each service.

Hospitals and other healthcare facilities are paid by Anthem in two different ways:

- A fixed amount of money for the service that Anthem and the hospital or facility agree upon in advance
- A lower amount of money for the service that Anthem and the hospital or facility agree upon in advance (You are not responsible for the difference.)

Your doctor may get financial incentives from Anthem. You may ask Anthem, your doctor, or your doctor's medical group for a written report of these incentives.

Some participating hospitals may have a special agreement referred to as reinsurance stop loss. This stop loss payment provision applies only to admissions certified by Anthem at an acute care level and where payments under this agreement are based on per diem rates.

First Line of Defense Against Fraud

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste, and abuse. Combating fraud, waste, and abuse begins with knowledge and awareness.

- *Fraud* - Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. The attempt itself is fraud, regardless of whether or not it is successful
- *Waste* - Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- *Abuse* - When healthcare providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

To help prevent fraud, waste, and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Learn more at **fighthealthcarefraud.com**.

Presentation of a member identification (ID) card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at **877-687-0549**.

Providers should encourage members to protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to the company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. Providers should instruct their patients who have lost their ID card to inspect their explanation of benefits (EOBs) for any errors and then contact member services if something is incorrect.

Reporting Fraud, Waste, and Abuse

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be

retaliated against for doing so. The name of the person and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

You can report your concerns by:

- Visiting our **fighthealthcarefraud.com** education site; at the top of the page click "Report it" and complete the "**Report Waste, Fraud, and Abuse**" form.
- Calling Provider Experience.
- Calling Customer Service.
- Call the SIU fraud hotline for California: **888-231-5044**.

Any incident of fraud, waste, or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of Provider Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a PROVIDER (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Examples of Member Fraud and Abuse

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID (identification) card

- Using someone else's ID card

Examples of Member Waste

- Violating pain management policies
- Overuse of emergency room services for non-emergent issues

When reporting concerns involving a MEMBER include:

- The member's name
- The member's date of birth, member ID, or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste, or abuse

Investigation Process

We investigate all reports of fraud, waste, and abuse for all services provided to members. If appropriate, allegations and the investigative findings are reported to the all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries, or may advise of further action.
- *Medical record review*: We review medical records to substantiate allegations or validate claims submissions.
- *Special claims review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU all checks and correspondence should be sent to:

Special Investigations Unit
740 W. Peachtree St. NW
Atlanta, GA 30308
Attn: investigator name, #case number

Paper medical records and claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **800-AVAILITY (282-4548)** for more information.

Acting on Investigative Findings

If, after investigation, the SIU determines a provider appears to have committed fraud, waste, or abuse the provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.
- Will be referred to other authorities as applicable and/or designated by the State.
- The SIU will refer all suspected criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily dis-enrolled from our healthcare plan. If appropriate and evidence suggests possible criminal behavior by a member, appropriate referrals to law enforcement are made.

Miscellaneous

California law also requires that we make these disclosures to you:

- The Anthem principal business address is 1099 N. Meridian St., Indianapolis, IN 46204.
- A copy of the plan contract will be furnished to you upon request.
- By statute, every contract between Anthem and a provider shall provide that, in the event Anthem fails to pay the provider, the subscriber shall not be liable to the provider for any sums owed by Anthem.
- In the event Anthem fails to pay nonparticipating providers, the subscriber may be liable to the nonparticipating providers for the cost of services.

Organ and tissue donation

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The Department of Health and Human Services' website (**www.organdonor.gov**) has additional information on donating your organs and tissues.

Public participation

We have a Community Advisory Committee to help our board of directors. This group is made up of members of our health plan, providers in the network and a member of our board. This group makes sure the comfort and dignity of our members is considered. It makes sure our services are easy to access for our members. The committee may look at the way we use our funding. They may also review complaints we receive from our members. The Community Advisory Committee reports to our board of

directors. If you would like to be considered for membership on the Community Advisory Committee, please call our Customer Care Center or TTY phone number.

Notifying you of changes in the plan

Throughout the year, we may send you updates about changes in the plan. This can include updates for the Provider Listing and EOC. We will keep you informed and are available to answer any questions you may have. Call us if you have any questions about changes in the plan.

Receipt of information

To administer claims on your behalf, we are entitled to receive service or treatment information about you from any provider. This right to receive information is subject to all applicable confidentiality requirements.

- By submitting an application for coverage, you have authorized every provider furnishing care to disclose all facts pertaining to your care, treatment, and physical condition, upon our request.
- You agree to assist in obtaining this information if needed.
- You can have access to your medical records.

Reimbursement for acts of third parties

You must advise us in writing within 60 days of filing a claim against a third party for any illness, injury, or condition for which that party may be liable or legally responsible. If you get money from the third party, you must reimburse Anthem for the amount of money we paid for your treatment.

Right to recovery

When any amount paid by Anthem exceeds the amount due under this EOC, Anthem has the right to recover the excess amount from the member unless prohibited by law.

Terms of coverage

- In order for you to be entitled to benefits under this plan, both your coverage in this plan and the administrative agreement between Anthem and MRMIP must be in effect on the date the expense giving rise to a claim for benefits is incurred.
- This plan, including all terms, benefits, conditions, limitations, and exclusions may be changed as may be permitted by the director without your consent or concurrence.
- The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date a member receives the service or supply for which the charge is made.
- Anthem is subject to the requirements of the Knox-Keene Health Care Service Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of the California Health and Safety Code and at Division 1 of Title 28 of the California Code of Regulations, and any provision required to be stated herein by either of the above shall bind Anthem whether or not provided in this plan. This

plan shall be construed and enforced in accordance with the laws of the state of California.
- Any provision of this plan, which, on its effective date, is in conflict with any applicable statute, regulation or other law, is hereby amended to conform with the minimum requirements of such law.
- Anthem shall provide written notice to you at least 60 days prior to any participating provider's or general acute care hospital's termination or breach of, or inability to perform under, any provider or general acute care hospital contract, if Anthem determines that you or your family members may be materially and adversely affected thereby.

Workers' Compensation Insurance

This EOC does not affect any requirement for or coverage by, workers' compensation insurance. It also does not replace that insurance.

If pursuant to any workers' compensation or employer's liability law or other legislation of similar purpose or import, a third party is responsible for all or other part of the cost of medical services provided by Anthem, we will provide the benefits of this agreement at the time of need. The member will agree to provide Anthem with a lien to the extent of the reasonable value of the services provided by Anthem. The lien may be filed with the responsible third party, his or her agent, or the court. For purposes of this subsection, reasonable value will be the usual, customary or reasonable charge for services in the geographic area where the services are rendered.

By accepting coverage under this agreement, members agree to cooperate in protecting the interest of Anthem under this provision and to executing and delivering to Anthem or its nominee any and all assignments or other documents which may be necessary, or proper, to fully and completely effectuate and protect the rights of Anthem or its nominee. Members also agree to fully cooperate with Anthem and not take any action that would prejudice the rights of Anthem under this provision.

Your healthcare rights and responsibilities

As a member of this health plan, you have the right to:

- Be informed of your rights and responsibilities.
- Be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
- Be able to talk honestly with your doctors about all the appropriate treatments for your condition, no matter what they cost or whether your benefits cover them.
- Be actively involved in making decisions about your healthcare.
- Be treated with respect and dignity in all situations.
- Have your privacy protected by Anthem, your doctors and all your other healthcare providers.
- Know that information about you is kept confidential. (Anthem will not share your health information without your written authorization or unless it is permitted by law.)
- Be in charge of your healthcare.
- Suggest changes in your health plan.
- Complain about Anthem or the healthcare you receive.
- Appeal an adverse decision from Anthem about the healthcare you requested or received.

- Request an IMR if Anthem denies, delays or modifies a healthcare service because it is not medically necessary.
- Make recommendations about our rights and responsibilities policy.
- Use interpreters who are not your family members or friends.
- Request an interpreter at no charge to you.

As a member of this health plan, you have the responsibility to:

- Give Anthem, your doctors, and other healthcare providers correct information needed to treat you.
- Understand your medical condition and help your doctor set treatment goals you both agree on.
- Follow the plans you have agreed to with your doctors and your other healthcare providers.
- Follow the guidelines for healthy living suggested by your doctor and your other healthcare providers.

Part 11 Definitions

Accidental Injury: Physical harm or disability which is the result of a specific, unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Active labor: Labor at a time when either of the following would occur:

- There is inadequate time to effect a safe transfer to another hospital prior to delivery
- Transfer poses a threat to the health and safety of the member or unborn child.

Outside of California or your service area, emergencies include urgently needed services to prevent serious deterioration of your health resulting from unforeseen illness or injury or complication of an existing condition, including pregnancy, and treatment cannot be delayed until you return to your service area. These urgently needed services will also be covered.

Ambulatory Surgical Center: A freestanding outpatient surgical facility that must be licensed as an outpatient clinic according to state and local laws, and must meet all requirements of an outpatient clinic providing surgical services. It also must meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Care.

Annual Benefit Maximum Limit: The maximum amount payable for all covered expenses incurred by a member during a year. All benefits furnished are subject to this maximum amount.

Annual Out-of-Pocket Maximum: This amount refers to the maximum amount you have to pay per year out of pocket for covered services before Anthem pays for your covered services. After the maximum is met, you will not have to pay any more copayments or coinsurance for services received from an in network provider, that apply to the out of pocket.

Authorized Referral: Occurs when a member's medical needs require the services of a specialist who is a nonparticipating provider, or when a member requires special services or facilities not available at a participating hospital, but only when all of the following conditions exist:

- There is no participating provider who practices in the appropriate specialty or there is no participating hospital that provides the required services or has the necessary facilities within the county where the member lives.
- The member is referred to the nonparticipating hospital or nonparticipating physician by a participating physician.
- The referral has been authorized by Anthem before services are rendered. In addition, Anthem will authorize a referral to a nonparticipating provider if there are no participating providers available or accessible.

Anthem Blue Cross: A healthcare service plan regulated by the California Department of Managed Health Care and contracting with the program to administer this plan.

Anthem Negotiated Fee: The fee that the Anthem pharmacy plan has negotiated with the participating pharmacy under a participating pharmacy agreement for covered expenses. Participating pharmacies have agreed to charge eligible Anthem members no more than the negotiated fee for covered

prescriptions.

Board: The Department of Health Care Services.

Brand-Name Prescription Drug: A prescription drug that has been patented and is produced by only one manufacturer.

Calendar Year: A 12-month period starting each January 1 at 12:01 a.m. Pacific Standard Time.

Child: The subscriber's unmarried, legally adopted child, stepchild, or recognized natural child living with the subscriber in a regular parent-child relationship. A child who is economically dependent on the subscriber where there exists a parent-child relationship with the subscriber.

Coinsurance: A member's percentage amount due and payable to the provider of care.

Complaint: A complaint is also called a grievance or an appeal. Examples of a complaint can be when:

- You can't get a service, treatment or medicine you need.
- Your plan denies a service and says it is not medically necessary.
- You have to wait too long for an appointment.
- You received poor care or were treated rudely.
- Your plan does not pay you back for emergency or urgent care that you had to pay for.
- You get a bill that you believe you should not have to pay.

Contracting Hospital: A hospital that has a contract with Anthem to provide care to our members. A contracting hospital is not necessarily a participating hospital. Please contact Anthem to determine if a hospital is contracting.

Copayment: A specific dollar amount that you must pay when you receive a covered service as described in the benefits description section. The dollar amount of the copay can be $0 (no charge).

Coordination of Benefits (COB) means that if you are covered by another health plan, that plan will pay first and the MRMIP health plan will pay second for any services you receive under the MRMIP program. The total of the two payments cannot be more than the total amount allowed by the MRMIP health plan. For more details on COB, please refer to page 14 under the section *Coordination of benefits*.

Cosmetic Surgery: Surgical procedures to alter or reshape normal structures of the body in order to improve appearance.

Cost Sharing: The copayments or coinsurance you are required to pay for covered services.

Covered Expense: The expense incurred by a member for covered services, but not more than the customary and reasonable charge or the maximum amounts stated in the applicable benefit sections of this EOC.

Covered Services: Medically necessary services or supplies listed in the benefits sections of this EOC that members are entitled to receive under this plan.

Creditable Coverage: 1. Any individual or group policy or program, that is written or administered by a disability insurance company, nonprofit hospital service plan, healthcare service plan, fraternal benefits society, self-insured employer plan or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital or surgical coverage not designed to supplement other private or

governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance. 2. The Federal Medicare Program pursuant to Title XVIII of the Social Security Act. 3. The Medicaid Program pursuant to Title XIX of the Social Security Act. 4. Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care, including, but not limited to, Medicare, Medicaid, The Peace Corps medical coverage, CHAMPUS, a medical care program of the Indian Health Service or of a tribal organization or state high risk benefits pool.

Custodial Care: Care provided primarily to meet the personal needs of the member. This includes help with walking, bathing, or dressing. It also includes preparing food or special diets, feeding, administration of medicine (usually self-administered), or any other care that does not require continuing services of medical personnel. Custodial care is not a covered benefit under this EOC, except to the extent included in hospice services.

Customary and Reasonable: A charge, as determined annually by Anthem, that falls within the common range of fees billed by a majority of providers, for a procedure in a given geographic region, or a charge that is justified based on the complexity or severity of treatment for a specific case.

Day Care Center: An outpatient psychiatric facility that is part of, or affiliated with, a contracting hospital. It must be licensed according to state and local laws to provide outpatient care and treatment of mental or nervous disorders under the supervision of psychiatrists.

Deductible: The amount you must pay in a calendar year for certain services before the plan will cover those services at the copayment or coinsurance amount within that calendar year.

Disenroll: To stop using the health plan because you lose eligibility, quit the health plan, or because you do not pay your monthly premium.

Drugs: Prescription drugs approved by the Food and Drug Administration

Drug Limited-Fee Schedule: The maximum amount Anthem pharmacy plan will consider as covered services when your prescription is filled at a nonparticipating pharmacy and is the lesser of billed charges or the average wholesale price (an accepted term in the pharmaceutical industry used as a benchmark for pricing).

Effective Date: The date your coverage under this EOC begins. It appears on your Anthem ID card.

Eligible Family Member: Any of the following persons who have been listed on the individual enrollment application completed by the subscriber and who qualify for coverage in accordance with all the rules of the program: spouse, registered domestic partner, children, stepchildren, and adopted children.

Emergency medical condition: A medical or psychiatric condition with such severe symptoms (including active labor or severe pain) that a prudent layperson, who has an average knowledge of health and medicine, could reasonably believe the lack of immediate medical attention could:

- Place your health or the health of your unborn baby in serious jeopardy
- Cause serious impairment to bodily functions
- Cause serious dysfunction of any bodily organ or part

Experimental Procedures or Services: Services that are not recognized under generally accepted medical standards as safe and effective for treating a particular condition.

Formulary (Drug List): A chosen list of drugs approved by Anthem that your doctor may prescribe for you.

FDA: Food and Drug Administration

Generic Prescription Drug: A pharmaceutical equivalent of one or more brand-name drugs. It must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the brand-name drug.

Healthcare Providers: Many kinds of doctors and specialists who are covered under this plan (for example, surgeons, doctors who treat cancer or doctors who treat special parts of your body). Providers must:

- Have a license to practice in California
- Give you a service that is paid for under this plan. Some of the healthcare providers include:
  – Audiologist: Tests your hearing
  – Certified Nurse Midwife (CNM): A clinician who cares for you during pregnancy and childbirth
  – Family Practitioner (FP): A doctor who treats general medical conditions for people of all ages
  – General Practitioner (GP): A doctor who treats general medical conditions
  – Licensed Vocational Nurse (LVN): Performs more complex nursing functions along with your doctor and is licensed with the state
  – Marriage, Family Therapist (MFT): Helps you with family problems
  – Medical Assistant (MA): A non-licensed person who helps your doctors give you medical services; may also be called a Certified Medical Assistant (CMA)
  – Nurse Anesthetist: A nurse who gives you anesthesia
  – Nurse Practitioner (NP) or Physician's Assistant (PA): Clinicians who can find out what is wrong, treat you, and take care of you
  – Obstetrician-Gynecologist (OB-GYN): A doctor who takes care of women's health, including prenatal care and delivery of babies
  – Occupational Therapist (OT): Helps you regain skills and activities of daily living after an illness or injury
  – Pediatrician: A doctor who only treats children from birth to adolescence
  – Physical Therapist (PT or RPT): Helps you rebuild your physical strength after an illness or injury
  – Podiatrist or Chiropodist (DPM, DSP, DSC): A foot doctor
  – Psychologist: A doctor who treats mental problems
  – Registered Nurse (RN): Has more extensive training than an LVN and is licensed with the state to perform certain complex duties along with your doctor
  – Respiratory Therapist (RT): Helps you with your breathing

– Speech Pathologist: Helps you with your speech

Home Health Agency and Visiting Nurse Associations: Give you skilled nursing care and other services in your home.

Hospital: A place you can get inpatient and outpatient care from doctors and nurses. They can find out what's wrong, treat and care for you there.

Infusion Therapy: The therapeutic use of drugs or other substances ordered by a physician, prepared, compounded or administered by a qualified provider, and given to the patient any way other than by mouth. Also includes all medically necessary supplies and durable medical equipment used in relation to the infusion therapy in any setting other than an acute inpatient hospital unit. This involves giving the patient medically necessary drugs or other substances through a vein. For purposes of this EOC, it shall also include medically necessary drugs or other substances given by aerosol or injection.

Inpatient Care: When you have to stay in the hospital or other facility to get the medical care you need.

Investigative Procedures: Procedures that have progressed to limited use on humans are not widely accepted as proven and effective procedures within the organized medical community. This includes articles or services that are not commonly used, either when used before all other more conventional therapies have been used and thoroughly reviewed, or those that have not been demonstrated as having significantly greater therapeutic value than other, less expensive services or articles.

Lifetime Maximum: The maximum amount that the plan agrees to pay for medical expenses on behalf of a member for covered services during the course of his or her lifetime (i.e. duration of the program), which is $750,000.

Maintenance Prescription Drugs: Prescription drugs that are taken for an extended period of time to treat a chronic medical condition.

Medically Necessary: Procedures, supplies, equipment, or services determined to fit all the following criteria:

- Appropriate for the symptoms, diagnosis, or treatment of a medical condition
- Provided for the diagnosis or direct care and treatment of the medical condition
- Within the standards of good medical practice within the organized medical community
- Not primarily for the convenience of the patient's physician or other provider
- The most appropriate procedure, supply, equipment, or service that can be safely provided

Medicare: The federal government's hospital and medical insurance program for the aged, totally disabled, and those with end-stage renal disease. There are two parts, A and B. Part A is the hospital portion and is mandatory for all eligible members. Effective December 1, 2000, United of Wisconsin (a subsidiary of BCBS of Wisconsin) is the Part A contractor in California. Part B is the physician portion and each Medicare eligible can decide to participate in it or not. Those who elect Part B coverage pay an additional premium to the federal government.

Member: The subscriber and all eligible family members who are enrolled for coverage under this plan.

Mental or Nervous Disorders: Conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (for

example, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Some mental or nervous disorders are: schizophrenia, manic depression, and other conditions usually classified in the medical community as psychosis; drug, alcohol, or other substance addiction or abuse; depressive, phobic, manic, and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline); dementia and delirious states; posttraumatic stress disorder; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa, and bulimia. Any condition meeting this definition is a mental or nervous disorder no matter what the cause. One or more of these conditions may be specifically excluded in this plan. However, medical conditions caused by behavior of the member that may be associated with these mental conditions (for example, self-inflicted injuries) are not subject to these limitations.

Negotiated Fee Rate: The rate of payment that Anthem has negotiated with the participating provider under a Prudent Buyer participating agreement for covered expense furnished to Prudent Buyer Plan members.

Negotiated Price (out-of-state providers only): The rate of payment that the On-Site Blue Cross and/or Blue Shield plan has negotiated with participating providers in their state. Often this negotiated price will consist of a simple discount. But sometimes it is an estimated flat dollar amount that has been agreed upon as expected payment with your healthcare provider or group of providers. The negotiated price may also be a discount from billed charges that reflects average expected savings. The estimated or average price may be adjusted to correct for over or underestimation of past prices.

Non-contracting Hospital: A hospital that has neither a standard contract nor a Prudent Buyer Plan participating hospital agreement with Anthem.

Nonparticipating Pharmacy: A pharmacy that does not have a participating pharmacy agreement in effect with Anthem pharmacy plan at the time services are rendered. You will be responsible for payment in full for any prescriptions purchased at a nonparticipating pharmacy.

Nonparticipating Provider: A provider who does **not** have a Prudent Buyer Plan Agreement with Anthem:

- A hospital
- A physician
- An ambulatory surgical center
- A home health agency or visiting nurse association
- A facility that provides diagnostic imaging services
- A clinical laboratory
- A home infusion therapy provider
- A licensed ambulance company
- A durable medical equipment outlet

Remember: only a portion of the amount that a nonparticipating provider charges for services may be considered for payment under this Plan. See *Part 5: Benefits summary* to determine the nonparticipating percentage allowances.

Office Visit: When you go to a provider's office and have one or more of **only** the following three services provided:

- History (gathering of information on an illness or injury)
- Examination
- Medical decision making (the physician's actual diagnosis and treatment plan)

For purposes of this definition, "office visit" will not include any other services while at the office of a provider (e.g. any surgical, infusion therapy, diagnostic X-ray, laboratory, pathology, and radiology), or any other services performed other than or in addition to any of the three services specifically listed above.

On-Site Blue Cross and/or Blue Shield Participating Provider: A hospital, physician, or other healthcare provider who has an agreement with the On-Site Blue Cross and/or Blue Shield plan within that state. This provider has negotiated with the On-Site Blue Cross and/or Blue Shield plan, certain charges as the negotiated price they will charge our members for covered services under this agreement.

On-Site Blue Cross and/or Blue Shield Plan: A Blue Cross and/or Blue Shield plan located outside the state of California. This on-site plan has an agreement with us to process claims for members in the event they receive services in another state.

Outpatient Care: When you do not have to stay in the hospital or other facility to get the medical care you need.

Paid Surrogate Mother: A subscriber who, before becoming pregnant, enters into an agreement to become pregnant and deliver a child for another person as the intended parent. This is done in exchange for money and not actual medical or living expenses.

Participating Health Plan: A health plan that has a contract with the program to administer major risk medical coverage for program subscribers.

Participating Hospital: A hospital that has a Preferred Provider Organization (PPO) participating agreement in effect with us at the time services are rendered. Participating hospitals agree to participate in procedures established to review the utilization of hospital services. We do not cover hospital services determined to be unnecessary, according to these utilization review procedures. A list of participating hospitals is available upon request.

Participating Pharmacy: A pharmacy that has a participating pharmacy agreement in effect with Anthem pharmacy plan at the time services are rendered.

Participating Physician: A physician who has a PPO participating agreement with Anthem at the time services are rendered. A list of participating physicians is available upon request.

Participating Provider: A participating physician or other health professional who has a Prudent Buyer or ambulatory surgical center participating agreement in effect with us at the time services are rendered.

Pharmacy: A licensed retail drug store.

Physician: A doctor of medicine (MD) or a doctor of osteopathy (DO) who is licensed to practice medicine or osteopathy where the care is provided.

Plan: The Anthem PPO plan described in this EOC and administered by Anthem for the state of

California.

Pre-existing Condition: An illness, injury, disease, or physical condition for which medical advice, diagnosis, care, or treatment, including the use of prescription drugs, was recommended by or received from a licensed health practitioner during the six months immediately preceding the member's effective date of coverage.

Preferred Participating Provider: A hospital that has entered into a preferred participating agreement with Anthem. A list of these providers is available upon request.

Prescription: A written order issued by a physician.

Prior Authorization: Determination by Anthem if services are medically necessary.

Program: The California Major Risk Medical Insurance Program. The program contracts with Anthem to administer this plan.

Psychiatric Mental Health Nurse: A registered nurse with a master's degree in psychiatric mental health nursing who meets the qualifications for registration and is registered as a psychiatric mental health nurse with the California Board of Registered Nurses.

Reconstructive surgery: Done when there is something wrong with a part of your body, including but not limited to birth defects, disease, or injury. It is done for medical reasons to make that part work better or to make it look more like it should.

Resident: A person who is present in California with the intent of remaining present except when absent for transitory or temporary purposes.

Rules of the Program: Statutes, laws and regulations of the board that govern the program and determine the qualifications for and rights and duties of members. The statutes are in Part 6.5 of Division 2 of the California Insurance Code and the regulations of the board are in Chapter 5.5, Title 10 of the California Code of Regulations.

Serious Condition: A condition that can cause loss of life, loss of limb, loss of bodily function, or substantial impairment including, but not limited to, a serious chronic condition.

Serious Emotional Disturbances (SED) means a diagnosed mental condition in a child that is not a "substance abuse disorder" or "developmental disorder." A child with SED also behaves in a way that is not appropriate for the child's age. A county mental health department decides if a child has SED based on California Law (Welfare and Institutions Code Section 5600.3(a)(2)). In making that decision, the county will consider whether a child has certain problems. These could include trouble taking care of him/herself, problems at school or problems with family relationships. The child also might have other problems such as being at risk of suicide or violence. The child also might meet the state's Special Education requirements. The county also may look at whether the child is at risk of being removed from the home and at how long the condition is expected to last.

Service Area: For Anthem, the state of California.

Severe Mental Illness (SMI) is a mental health condition that includes: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and

bulimia nervosa.

Skilled Nursing Facility: A place that gives you 24-hour-a-day nursing service that only a trained health professional may give.

Special Care Units: Special areas of a hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Subscriber: An individual who is eligible for and receives coverage through the program. *Subscriber* does not include an individual receiving coverage through the program as the enrolled child of a subscriber.

Telehealth: The mode of delivering healthcare and public health services utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patient at a distance from healthcare providers.

Third-party corporate telehealth provider: A corporation directly contracted with a plan that provides healthcare services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services.

Triage or Screening means 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. [This definition only applies for the purposes of the plan's obligations under Title 28, Section 1300.67.2.2.]

Triage or Screening Waiting Time means the time waiting to speak by telephone with a doctor or nurse who is trained to screen a member who may need care. This definition only applies for the purposes of the plan's obligations under Title 28, Section 1300.67.2.2.

We (us, our): Refers to Anthem.

You (your): Refers to the subscriber and eligible family members who are enrolled for benefits under this EOC.

HIPAA Notice Of Privacy Practices

The original effective date of this notice was April 14, 2003. This notice was most recently revised in June 2022.

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 healthcare.

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 papers 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 healthcare 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, healthcare 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 healthcare or services before you get them
  - To find ways to make our programs better, and to support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations, and treatment. If you don't want this, please visit **anthem.com/ca/privacy** for more information.
- **For healthcare 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 healthcare, if you tell us it's OK
  - With someone who helps with or pays for your healthcare, 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 will have 30 days to send it to you. If we need more time, we have to let you know. 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. We will have 60 days to send it to you. If we need more time, we have to let you know.
- 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 healthcare, payment, everyday healthcare business, or some other reasons we didn't list here. We will have 60 days to send it to you. If we need more time, we have to let you know.

- 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.

Contacting you

We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call **844-203-3796** to add your phone number to our Do Not Call list.

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call the Customer Care Center toll free at **800-407-4627** or **888-285-7801** for members in Los Angeles Monday through Friday, 7 a.m. to 7 p.m. Pacific time. If you are deaf or hard of hearing, call **TTY 711**.

To see more information

To read more information about how we collect and use your information, your privacy rights, and details about other state and federal privacy laws, please visit our Privacy webpage at **https://www.anthem.com/privacy.**

What if you have a complaint?

We're here to help. If you feel your PHI hasn't been kept safe, you may call the Customer Care Center 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: **800-368-1019**
TDD: **800-537-7697**
Fax: 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: **916-445-4646**
Fax: 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
916-440-7000 or **800-579-0874**
Fax: 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 will also post them on the web at **anthem.com/ca/medi-cal**.

Race, ethnicity, language, sexual orientation, and gender identity

We get race, ethnicity, language, sexual orientation, and gender identity 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.
- Create and send health education information.
- Let doctors know about your language needs.
- Provide interpretation and translation services.

We do **not** use this information to:

- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Share with unapproved users.

Your personal information

We may ask for, use, and share personal information (PI) as we talked about in this notice. Your PI is not public, and tells us who you are. It's often taken for insurance reasons.

- We may use your PI to make decisions about your:
  - Health
  - Habits
  - Hobbies
- We may get PI about you from other people or groups like:
  - Doctors
  - Hospitals
  - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

anthem.com/ca/medi-cal

Anthem Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Revised June 2022

1044459CAMMLABC 08/22

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 **877-687-0549 (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:

Grievance Coordinator
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA, 90060-0007
Phone for MRMIP: 877-687-0549
(TTY 888-757-6034)

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**
- By mail: **U.S. Department of Health and Human Services**
  200 Independence Ave. SW
  Room 509F, HHH Building
  Washington, DC 20201
- By phone: **800-368-1019 (TTY/TDD 800-537-7697)**

For a complaint form, visit **hhs.gov/ocr/office/file/index.html.**

NONDISCRIMINATION NOTICE

Discrimination is against the law. Anthem Blue Cross follows State and Federal civil rights laws. Anthem does not unlawfully discriminate, exclude people, or treat them differently because of **sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.**

Anthem provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact Anthem between Monday and Friday, 7 a.m. to 7 p.m. by calling toll free at 800-407-4627 or 888-285-7801 (TTY 711) for members in Los Angeles. If you cannot hear or speak well, please call TTY 711. Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

For members in Los Angeles:

Anthem Blue Cross
P.O. Box 9054
Oxnard, CA 93031-9054
888-285-7801 (TTY 711) toll free, Monday-Friday, 7 a.m.-7 p.m.

For all other members:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007
800-407-4627 (TTY 711) toll free, Monday-Friday, 7 a.m.-7 p.m.

HOW TO FILE A GRIEVANCE

If you believe that Anthem has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with our grievance coordinators. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact our grievance coordinators between Monday and Friday, 7 a.m. to 7 p.m. by calling toll free at 800-407-4627 or 888-285-7801 (TTY 711) for members in Los Angeles. Or, if you cannot hear or speak well, please call TTY 711.

- In writing: Fill out a complaint form or write a letter and send it to:

  For members in Los Angeles:

  Grievance Coordinator
  Anthem Blue Cross
  P.O. Box 9054
  Oxnard, CA 93031-9054

  For all other members:

  Grievance Coordinator
  Anthem Blue Cross
  P.O. Box 60007
  Los Angeles, CA 90060-0007

- In person: Visit your doctor's office or Anthem and say you want to file a grievance.
- Electronically: Visit Anthem website at anthem.com/ca/medi-cal.

OFFICE OF CIVIL RIGHTS: CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- In writing: Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights Department of Health Care Services Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call

  TTY/TDD 1-800-537-7697.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building

Washington, D.C. 20201

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

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Language Assistance

English

Do you need help with your healthcare, talking with us, or reading what we send you? We provide our materials in other languages and formats, including braille, large print, and audio at no cost to you. Call us toll free at 800-407-4627 (TTY 711), or 888-285-7801 (TTY 711) for members in Los Angeles.

Español (Spanish)

¿Necesita ayuda con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos, incluyendo braille, letras grandes y audio sin costo para usted. Llámenos a la línea gratuita al 800-407-4627 (TTY 711), o 888-285-7801 (TTY 711) para miembros en Los Angeles.

中文(Chinese)

您在醫療保健、向我們諮詢、或是閱讀我們寄給您的資料時有需要任何的幫助嗎？我們以其他語言和格式提供我們的資料，包括點字、大型字體印刷和音訊格式，您無需支付任何費用。歡迎撥打我們的免費電話 800-407-4627 (TTY 711)，Los Angeles 的會員或可致電 888-285-7801 (TTY 711)。

Tagalog (Tagalog)

Kailangan ba ninyo ng tulong sa inyong pangangalagang pangkalusugan, sa pamamagitan ng pakikipag-usap sa amin o pagbasa sa kung ano ang ipinapadala namin sa inyo? Nagbibigay kami ng aming mga materyal sa ibang mga wika at anyo, kasama ang braille, malaking titik at audio na wala kayong gagastusin. Tumawag sa amin nang walang toll sa 800-407-4627 (TTY 711), o 888-285-7801 (TTY 711) para sa mga miyembro sa Los Angeles.

Tiếng Việt (Vietnamese)

Quý vị có cần chúng tôi giúp với việc chăm sóc sức khỏe của quý vị, trao đổi với chúng tôi, hoặc đọc những tài liệu chúng tôi gửi cho quý vị hay không? Chúng tôi cung cấp các tài liệu bằng các ngôn ngữ và định dạng khác, bao gồm chữ nổi, chữ in lớn và âm thanh, miễn phí cho quý vị. Hãy gọi cho chúng tôi theo số điện thoại miễn cước 800-407-4627 (TTY 711), hoặc 888-285-7801 (TTY 711) dành cho các hội viên tại Los Angeles.

한국어(Korean)

의료 서비스, 당사와의 소통 또는 당사에서 보내는 자료 읽기와 관련해 도움이 필요하십니까? 점자, 대형 활자, 오디오 등을 비롯하여 다른 언어나 형식으로 자료를 무료로 제공해 드립니다. 800-407-4627 (TTY 711) 번으로 연락하시거나 로스앤젤레스 회원은 888-285-7801 (TTY 711) 번으로 무료로 연락하시기 바랍니다.

Հայերեն (Armenian)
Դուք օգնության կարիք ունե՞ք Ձեր առողջապահական խնամքի, մեզ հետ խոսելու կամ մեր կողմից Ձեզ ուղարկվածը կարդալու հարցում: Մենք մեր նյութերը Ձեզ անվճար տրամադրում ենք այլ լեզուներով և ձևաչափերով, այլ թվում Բրայլով, մեծ տպագրությամբ և աուդիո տարբերակով: Los Angeles-ում գտնվող անդամների համար զանգահարե՛ք 800-407-4627 (հեռատիպ՝ 711) կամ 888-285-7801 (հեռատիպ՝ 711) հեռախոսահամարով:

فارسی (Farsi)
آیا در رابطه با مراقبت بهداشتی درمانی خود، گفتگو با ما یا خواندن مطالب ارسالی به شما، به کمک نیاز دارید؟ ما مطالب خود را به سایر زبان‌ها و قالب‌ها شامل خط بریل، چاپ درشت و صوتی، به صورت رایگان به شما ارائه می‌دهیم. اعضای ساکن لس آنجلس می توانند از طریق شماره رایگان 800-407-4627 (TTY 711) یا 888-285-7801 (TTY 711) با ما تماس بگیرند.

العربية (Arabic)
هل تحتاج إلى مساعدة بخصوص رعايتك الصحية أو التحدث معنا أو قراءة ما نرسله إليك؟ نحن نقدم المواد الخاصة بنا بلغات وتنسيقات أخرى، بما في ذلك بطريقة بريل والطباعة بحروف كبيرة والملفات الصوتية، بدون أي تكلفة عليك. يُرجى الاتصال بنا على الرقم المجاني 800-407-4627 (الهاتف النصي 711) أو على رقم 888-285-7801 (الهاتف النصي 711) بالنسبة للأعضاء المقيمين في لوس أنجلوس.

Русский (Russian)
Вам нужна помощь с медицинским обслуживанием, консультацией или материалами, которые мы вам прислали? Мы можем бесплатно предоставить вам материалы на других языках и в других форматах, включая шрифт Брайля, крупный шрифт или аудиоформат. Звоните нам по бесплатному номеру 800-407-4627 (TTY 711) или 888-285-7801 (TTY 711) для участников, проживающих в Лос-Анджелесе.

हिन्दी (Hindi)
क्या आपको अपनी स्वास्थ्य देखभाल के लिए, हमसे बात करने के लिए या जो हम आपको भेजते हैं उसे पढ़ने के लिए, मदद की ज़रूरत है? हम अपनी सामग्री को अन्य भाषाओं और प्रारूपों में आपको बिना किसी लागत के उपलब्ध कराते हैं, जिसमें ब्रेल, बड़े प्रिंट, और ऑडियो शामिल हैं। हमें टॉल फ्री नंबर 800-407-4627 (TTY 711) पर कॉल करें, या लॉस एंजेलिस में सदस्यों के लिए 888-285-7801 (TTY 711) पर कॉल करें।

日本語 (Japanese)
ヘルスケアに関してご質問やご相談はありませんか？当社からお送りした資料のことでお困りですか？資料は英語以外の言語のほか点字や読みやすい大きな活字、音声版もご用意しています。いずれも無料です。フリーダイヤル 800-407-4627 (TTY 711)、ロサンゼルスにお住まいの方は 888-285-7801 (TTY 711) までお電話ください。

ភាសាខ្មែរ [Khmer (Cambodian)]
តើលោកអ្នកត្រូវការជំនួយជាមួយនឹងការថែទាំសុខភាពរបស់លោកអ្នក ការពិគ្រោះជាមួយយើងខ្ញុំ ឬការអានឯកសារអ្វីដែលយើងខ្ញុំផ្ញើជូនលោកអ្នកឬ? យើងផ្តល់ជូនឯកសាររបស់យើងជាភាសា និងទម្រង់ផ្សេងទៀត ដែលរួមមានអក្សរសម្រាប់ជនពិការភ្នែក អក្សរបោះពុម្ពធំៗ និងជាសំឡេង ដោយមិនគិតថ្លៃពីលោកអ្នកឡើយ។ សូមហៅទូរស័ព្ទដោយឥតគិតថ្លៃតាមរយៈលេខ 800-407-4627 (TTY 711) ឬ 888-285-7801 (TTY 711) សម្រាប់សមាជិកនៅក្នុងទីក្រុង Los Angeles។

Hmoob (Hmong)
Koj puas xav tau kev pab hais txog kev saib xyuas mob nkeeg rau koj, tham nrog peb los sis pab nyeem daim ntawv peb xa tuaj rau koj? Peb pab txhais cov ntaub ntawv pub dawb rau koj xws li muab txais ua lwm hom ntawv thiab muab sau ua lwm yam xws li cov ntawv sau rau cov neeg dig muag xuas, muab luam tawm kom loj thiab kaw ua suab lus. Hu peb ntawm tus xov tooj hu dawb ntawm 800-407-4627 (TTY 711), los sis 888-285-7801 (TTY 711) rau cov tswv cuab nyob hauv Los Angeles.

ਪੰਜਾਬੀ (Punjabi)
ਕੀ ਤੁਹਾਨੂੰ ਆਪਣੀ ਸਿਹਤ ਸੰਭਾਲ ਦੇ ਲਈ, ਸਾਡੇ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਜਾਂ ਜੋ ਅਸੀਂ ਤੁਹਾਨੂੰ ਭੇਜਦੇ ਹਾਂ, ਉਸਨੂੰ ਪੜ੍ਹਨ ਲਈ ਮਦਦ ਦੀ ਜਰੂਰਤ ਹੈ? ਅਸੀਂ ਆਪਣੀ ਸਮੱਗਰੀ ਨੂੰ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਅਤੇ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਦੇ ਮੁਹੱਈਆ ਕਰਵਾਉਂਦੇ ਹਾਂ, ਜਿਸ ਵਿੱਚ ਬ੍ਰੇਲ, ਵੱਡੇ ਪ੍ਰਿੰਟ ਅਤੇ ਆਡੀਓ ਸ਼ਾਮਲ ਹਨ। ਲਾਸ ਐਂਜਲਸ ਵਿੱਚ ਰਹਿੰਦੇ ਮੈਂਬਰ, ਸਾਨੂੰ ਟੋਲ ਫ਼ਰੀ ਨੰਬਰ 800-407-4627 (TTY 711) ਜਾਂ 888-285-7801 (TTY 711) 'ਤੇ ਕਾਲ ਕਰ ਸਕਦੇ ਹਨ।

ลาว (Laotian)
ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອກ່ຽວກັບການເບິ່ງແຍງດູແລສຸຂະພາບຂອງທ່ານ, ລົມກັບພວກເຮົາ, ຫຼື ອ່ານສິ່ງທີ່ພວກເຮົາສົ່ງໃຫ້ທ່ານບໍ? ພວກເຮົາສະໜອງເອກະສານຂອງພວກເຮົາໃຫ້ເປັນພາສາອື່ນ ແລະ ຢູ່ໃນຟໍແມັດຕ່າງໆ, ລວມທັງອັກສອນນູນ, ການພິມຂະ ໜາດ ໃຫຍ່, ແລະສຽງໂດຍບໍ່ເສຍຄ່າໃດໆ. ໂທຫາພວກເຮົາໄດ້ຟຣີທີ່ເບີ 800-407-4627 (TTY 711), ຫຼື 888-285-7801 (TTY 711) ສຳ ລັບສະມາຊິກໃນ Los Angeles.

ไทย (Thai)
คุณต้องการความช่วยเหลือเกี่ยวกับการดูแลสุขภาพของคุณ การปรึกษาเรา หรือการอ่านข้อมูลที่เราส่งให้คุณหรือไม่ เราให้บริการข้อมูลในภาษาและรูปแบบอื่นๆ ซึ่งรวมถึงอักษรเบรลล์ การขยายขนาดอักษร และข้อความเสียงโดยไม่คิดค่าใช้จ่าย โทรหาเราได้ฟรีที่หมายเลข 800-407-4627 (TTY 711) หรือ 888-285-7801 (TTY 711) สำหรับสมาชิกในลอสแอนเจลิส

Українська (Ukrainian)
Вам потрібна допомога з медичним обслуговуванням, у розмові з нами або читанні матеріалів, які ми вам надсилаємо? Ми безкоштовно надаємо наші матеріали іншими мовами та в інших форматах, включаючи шрифт Брайля, великий шрифт і аудіо-формат.

Телефонуйте нам безкоштовно за номером 800-407-4627 (TTY 711) або 888-285-7801 (TTY 711) для учасників, які мешкають у Los Angeles.

Mienh waac (Mien)
Meih qiemx longc mienh tengx goux mangc taux meih nyei buonh sin heng-wangc nor, ca'laangh caux yie mbuo, a'fai tengx doqc mangc dungh yie mbuo fungx bun meih wuov deix sou fai? Yie mbuo dor sou-muotc jaa-dorngx benx da'nyeic fingz waac daaih bun aengx caux sou-guv daan, lemh jienv nzangc-pokc, aamz benx domh sou-fangx aengx caux waac-qiez bun wang-henh muangx maiv zuqc feix luic meih cuotv nyaanh. Longc wang-henh douc waac fonh yiem naaiv 800-407-4627 (TTY 711), a'fai 888-285-7801 (TTY 711) liouh zuangx mienh muoz haaix dauh yiem njiec Los Angeles.