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

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

ما يمكن ترجمته بثمن. اتصل بالرقم الذي يظهر على بطاقة التعريف (ID Card).

們可以免費為您提供翻譯版本。請撥打您的ID卡上所列的電話號碼洽詢客戶服務中心。

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

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

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

Welcome to your health plan and thank you for choosing Anthem Blue Cross, California’s oldest and newest health benefits company. You may know us as Blue Cross of California. Even though we have changed our name, our purpose is the same – to be there for you. You are getting this book with all the information you need to get the most from your Medi-Cal program. In this book, you will find these:

**Member Handbook**

This section explains:
- How your health plan works.
- What your plan covers and does not cover.
- Your member rights and responsibilities.
- Important phone numbers.

**Other Things to Know About Your Health Plan**

This section explains:
- How we keep your health information private.
- 24/7 NurseLine, a 24-hour nurse help line.
- Checkups to help keep you and your family healthy.
- What to do if you are pregnant.

Please read about how to get an OK from Anthem Blue Cross or how to get specialty care. You must have an OK from us before you get some types of specialty care.

**Make sure you use providers in the Anthem Blue Cross network.** If no one in the network can give you the care you need, your primary care physician (PCP) will get an OK from us to send you to a provider that is not in the network. For emergency or urgent care, you do not need to get an OK from us at all. You do not need an OK from us or need to be referred by your PCP to get family planning care. You may go to any qualified family planning provider. **If you do not have a health care emergency, you must use a provider in the network.** If you get nonemergency care from a provider that is not in the network before you get the required OK from us, you will have to pay for that service.

**Your member ID card has been sent to you in a separate mailing.** Your ID card lists your PCP. If you want to change your PCP, choose one from the Anthem Blue Cross Provider Directory. Then fill out and send us the PCP Selection Form found at the back of this book. Call us if you need a Provider Directory. If you need help or have not received your ID card yet, please call us toll-free at 1-888-285-7801. If you have hearing or speech loss, you may call the TTY line at 1-888-757-6034.
You can rely on Anthem Blue Cross to help you get the most from your health plan. Why? Because we've been helping Californians get access to quality care for a long, long time. The bottom line? You can count on us to help you get the coverage you and your family need.

**Choose Your Primary Care Physician (PCP)**
- You will have lots of PCPs to choose from.
- It's easy to change your PCP if you need to.
- Your PCP can even refer you to available health education classes at no cost to you.

**Help Through Our Community Resource Services**
- Talk one-on-one with our friendly staff.
- Get help finding a PCP.
- Learn about your health plan.
- Find out about services near you.

**A Trusted Company**
- Rely on access to quality health care benefits serving California since 1937.
- Get the finest in medical coverage from people you already know.

**Visit Us at anthem.com/ca**
- Learn about our programs for your health.
- Get news about your health plan.
- Find a PCP, and more.
Get Answers from 24/7 NurseLine
- Talk in private with a nurse about your health.
- Specially trained nurses can talk to teens about teen health issues.
- Access hundreds of health topics over the phone.

Help for Your Good Health
The better you feel, the more you can enjoy life. That’s where we can help. We offer many ways to help you learn how to become healthier and reduce health risks. We want to help you take good care of yourself and your family.

Control Your Asthma
- Get our Healthy Habits Count with Asthma member packet with facts about how to help control your asthma.
- Learn how to control your asthma through classes (where available) at no cost to you.

Manage Your Diabetes
- Ask for our Healthy Habits Count with Diabetes member packet for facts on how to help manage your diabetes through diet, exercise and health tests.
- Learn how to manage your diabetes through classes (where available) at no cost to you.

Take Care of Your Heart
- Get our Healthy Habits Count for Your Heart member packet with facts that can help you handle signs of illness.
- Learn how to detect signs of heart disease through classes (where available) at no cost to you.

Stop Smoking
- Get a free Quit Kit to help you quit for good.
- Sign up for classes and support groups to help you quit, at no cost to you.

Call Us If You’re Pregnant
- If you’re pregnant call us right away at 1-888-285-7801.
- Take childbirth classes in your area (where available) at no cost to you.
- Get a Healthy Habits Count for You and Your Baby program packet with facts that can help while you are pregnant.
- Get a reward when you see your PCP after your baby is born.

Practice Preventive Care
- Make sure your children get Child Health and Disability Prevention (CHDP) program services. (See the CHDP page located near the back of this book.) Ask your PCP about the services that are right for your children.
- Be sure you and your children get needed checkups and shots. We even give you reminders.
- Make sure you get your children tested for lead poisoning at ages 1 and 2. All children must take a lead test at least once by age 6.
- Call 24/7 NurseLine to access audiotapes on family planning and how to avoid sexually transmitted diseases like HIV/AIDS.

Help Kids Learn Healthy Habits
- Learn how your family can eat right and get fit.
- Get more active. Our Get Up and Get Moving! workbook can help you and your family live a healthy lifestyle.

Questions? Just call!
We’re glad you’re a member of our health plan. If you have any questions, please call us at 1-888-285-7801. If you have hearing or speech loss, you may call our TTY line at 1-888-757-6034.
As an L.A. Care/Anthem Blue Cross member, you have the right to …

Respectful and courteous treatment. You have the right to be treated with respect, dignity and courtesy from your health plan’s providers and staff. You have the right to be free from retaliation or force of any kind when making decisions about your care.

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

Choice and involvement in your care. You have the right to receive information about your health plan, its services, its doctors and other providers. You have the right to choose your primary care provider (PCP doctor) from the doctors and clinics listed in your health plan’s provider directory. You also have the right to get appointments within a reasonable amount of time. You have the right to talk with your doctor about any care your doctor provides or recommends, discuss all treatment options and participate in making decisions about your care. You have the right to a second opinion. You have the right to talk candidly to your doctor about appropriate or medically necessary treatment options for your condition, regardless of the cost or what your benefits are. You have the right to information about treatment regardless of the cost or what your benefits are. You have the right to say “no” to treatment. You have a right to decide in advance how you want to be cared for in case you get a life-threatening illness or injury.

Voice your concerns. You have the right to complain about L.A. Care, the health plans and providers we work with, or the care you get without fear of losing your benefits. L.A. Care will help you with the process. If you don’t agree with a decision, you have the right to appeal, which is to ask for a review of the decision. You have the right to disenroll from your health plan whenever you want. As a Medi-Cal member, you have the right to request a State Fair Hearing.

Service outside of your health plan’s provider network. You have the right to receive emergency or urgent services as well as family planning and sexually transmitted disease services outside of your health plan’s network. You have the right to receive emergency treatment whenever and wherever you need it.

Service and information in your language. You have the right to request an interpreter at no charge instead of using a family member or friend to interpret for you. You should not use children to interpret for you. You have the right to get the Member Handbook and other information in another language or format (such as audio, large print or Braille).

Know your rights. You have the right to receive information about your rights and responsibilities. You have the right to make recommendations about these rights and responsibilities.

As an L.A. Care/Anthem Blue Cross member, you have a responsibility to …

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

Give up-to-date, accurate and complete information. You are responsible for giving correct information and as much information as
you can to all of your providers, to Anthem Blue Cross and to L.A. Care. You are responsible for getting regular checkups and telling your doctor about health problems before they become serious.

**Follow your doctor’s advice and take part in your care.** You are responsible for talking over your health care needs with your doctor, developing and agreeing on goals, doing your best to understand your health problems, and following the treatment plans and instructions you both agree on.

**Use the Emergency Room only in an emergency.** You are responsible for using the emergency room in cases of an emergency or as directed by your doctor.

**Report wrongdoing.** You are responsible for reporting health care fraud or wrongdoing to L.A. Care. You can do this without giving your name by calling the L.A. Care Compliance Helpline toll-free at **1-800-400-4889** or you could call the Department of Health Care Services (DHCS) Medi-Cal Fraud and Abuse Hotline toll-free at **1-800-822-6222**.
Benefit Year 2010-2011

Medi-Cal Member Handbook
... a helpful guide to getting services
(Combined Evidence of Coverage & Disclosure Form)

L.A. Care Health Plan
555 West Fifth Street
Los Angeles, CA 90013
Toll-free: 1-888-839-9909
TTY/TDD: 1-866-LACARE1 (1-866-522-2731)
Fax: 1-213-623-8097
Office Hours: Monday through Friday, 8 a.m. to 5 p.m.
Website address: lacare.org

Anthem Blue Cross
P.O. Box 9054
Oxnard, CA 93031-9054
Toll-free: 1-888-285-7801
TTY/TDD: 1-888-757-6034
Office Hours: Monday thru Friday, 7 a.m. to 7 p.m.
Website address: anthem.com/ca
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WELCOME: Thank you for choosing L.A. Care Health Plan!

L.A. Care is a government agency that was created over 10 years ago to help Los Angeles County Medi-Cal members get quality health care. L.A. Care is also called the Local Initiative Health Authority for Los Angeles County. But you can call us “L.A. Care.”

With the help of the health plans we work with, L.A. Care serves nearly 800,000 members in Los Angeles County. We only serve people who live in Los Angeles County (called our “service area”). L.A. Care Health Plan is the largest public health plan in the nation. We are growing because we are a trusted source for health care and we respect our members.

When your care starts

To enroll in the Medi-Cal program, call or visit the Los Angeles County Department of Public Social Services office (DPSS) near you. Once DPSS finds you eligible, you can enroll in a health plan of your choice. Enrollment in a health plan can take between 15 to 45 days.

While your enrollment in a health plan is processed, you can access your Medi-Cal benefits using the Benefits Identification Card (BIC) sent to you by the California Department of Health Care Services. The benefits you access during this time are covered by Medi-Cal.

Your care through L.A. Care and Anthem Blue Cross starts when your enrollment in a health plan is complete. You can start using your Medi-Cal benefits through L.A. Care and Anthem Blue Cross on your effective date of coverage. Your effective date of coverage is the 1st day of the month following completion of enrollment in a health plan. Check the Anthem Blue Cross member ID card mailed to you for the effective date of coverage.

Your health plan choices with L.A. Care

L.A. Care works with five (5) Health Plan Partners to provide health care services for members.

L.A. Care and the Health Plan Partners have contracts with many doctors, hospitals, pharmacies and other health care providers to serve you. When a Medi-Cal member joins L.A. Care, the member can choose to receive services through:

- Anthem Blue Cross
- Care1st Health Plan
- Community Health Plan
- Kaiser Permanente
- L.A. Care Health Plan

L.A. Care and the Health Plan Partners are prepaid health coverage programs called “health maintenance organizations,” or HMOs. L.A. Care and the Health Plan Partners are licensed with the State of California. The State of California has given L.A. Care and the Health Plan Partners permission to serve you. The State of California pays for your health care. **There is no cost to you when you get services covered by Medi-Cal.**

When you chose L.A. Care for your Medi-Cal, you also chose Anthem Blue Cross as your health plan. (If you did not choose a health plan, we chose one for you.) **Anthem Blue Cross is responsible for almost all of your health care services.** Some benefits, like dental and vision, are not provided by your health plan. You can learn more about this in the “More benefits: What other services can I get?” section of this handbook.
How to change health plans

We believe you will like Anthem Blue Cross. But you can change your health plan for any reason. Call **L.A. Care at 1-888-839-9909 to change your health plan**. If you call L.A. Care before the 20th of the month, the change will be effective on the 1st of the next month. If you call L.A. Care on or after the 20th of the month, the change will start on the 1st of the month following the next month. For example, if you call on June 15th to change health plans, the change will become effective on July 1st. If you call after June 20th to change health plans, the change will become effective August 1st. When you change health plans, you will get an ID card from your new health plan. Be sure to tear up your old health plan ID card.

Some plans do not serve all of Los Angeles County. Call the health plan to ask about their service area and to make sure it can serve you before you change. You can’t get routine care like checkups outside of your health plan’s service area. But don’t worry – no matter which health plan you choose, you can get urgent or emergency care anywhere when you need it— even outside of Los Angeles County. For more information, see the “Emergency care: How do I get care in an emergency?” section of this handbook.

How to change your Health Maintenance Organization (HMO)

You can also leave L.A. Care to enroll with another HMO at any time and for any reason. To change your HMO, call Health Care Options (HCO). You can find HCO’s phone number in the “Important Phone Numbers” section of this handbook. When you change your HMO, you will get a new ID card and Member Handbook from your new HMO. Be sure to tear up your old ID card.
This Member Handbook: Why is it important to you?

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

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

In this handbook, we use “you” and “your” to mean “the Medi-Cal member.” Only the member can get the benefits talked about in this handbook.

Your Member Handbook is also called the Combined Evidence of Coverage and Disclosure Form. It gives only a summary of L.A. Care Health Plan policies and rules. You must look at the contract between L.A. Care and the California Department of Health Care Services (DHCS) to learn the exact terms and conditions of coverage. Call L.A. Care if you would like a copy of the contract.

Need this handbook in another language?

Call Anthem Blue Cross if you would like your handbook in this language. (English)

Llame a Anthem Blue Cross si desea una copia del manual en este idioma. (Spanish)

Ծամասեր Անթեմ Բլու Քրեսս եթե անում եք թերթը (Հայերեն)

Anthem Blue Cross에서 전화를 하시면 이 핸드북을 다른 언어로 받아보실 수 있습니다. (Korean)

Позвоните в офис Anthem Blue Cross, если Вам необходим данный справочник на следующем языке. (Russian)

Xin gọi Anthem Blue Cross nếu quý vị muốn có cuốn cẩm nang bằng ngôn ngữ này. (Vietnamese)

Call Anthem Blue Cross if you would like this handbook or other member materials that you may receive from Anthem Blue Cross in large print, Braille, audio or an alternate format.

Whom do I call and when?

You can call your Primary Care Provider (PCP) – your doctor – when you:

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

Your doctor’s name and telephone number are on your ID card.

You can call Anthem Blue Cross when you:
• Need a new ID card.
• Want to change your PCP doctor.
• Have questions about services and how to get them.
• Want to know what’s covered or what is not covered.
• Need help getting care.
• Get a bill from a doctor.
• Are pregnant.
• Have a problem you can’t solve.

Anthem Blue Cross’ toll-free number is 1-888-285-7801.

You can call L.A. Care Health Plan when you:
• Have a problem you can’t resolve
• Get a bill from a doctor
• Want to change health plans from Anthem Blue Cross to a different health plan
• Are unsure who to call

L.A. Care’s toll-free number is 1-888-839-9909.

Helpful information on the Internet at lacare.org

Do you use the Internet? Our website, lacare.org, is a great resource. You can:
• Find a doctor
• Learn about the nurse advice line and how and when to use it
• Learn about your benefits
• Learn more about privacy rights
• Learn about health education services
• Find out about your rights and responsibilities
• Learn about fraud, waste and abuse, and how to report suspected fraud, waste and abuse
• File a complaint (called a “grievance”)

You can also check your eligibility for medical coverage. You can even request to change your health plan. Since this information is private, you will need to log in. Go to lacare.org to find out what to do.

Be sure to have your ID card ready because we will ask for your member ID number.
Let’s get started: How do I get health care?

In this handbook, we will call your primary care provider (PCP) your “PCP doctor.” Your PCP doctor is responsible for making sure you get the medical care you need and are entitled to.

You were asked to choose a PCP doctor and a health plan when you filled out the Medi-Cal enrollment form. Sometimes we can’t give you the PCP doctor you choose. Some of the reasons are:

- The doctor is not taking new patients.
- The doctor does not work with the health plan you chose.
- The doctor only sees patients of a certain age or only women (OB/GYNs).
- The doctor does not work with L.A. Care.

If you did not get the PCP doctor or health plan you chose, call L.A. Care at 1-888-839-9909 to see if that PCP doctor or health plan is available.

Each member has a PCP doctor. A PCP doctor can even be a clinic. You can choose one PCP doctor for all members of your family in Medi-Cal. Or you can choose a different PCP doctor for each member of your family in Medi-Cal. Women can choose an OB/GYN or family planning clinic as their PCP doctor.

Your PCP doctor

Your PCP doctor gives you “primary” (or basic) medical care. Health care services you can get from your PCP doctor include:

- Routine care.
- Checkups (also called “well visits”). This is when you go to your PCP doctor when you are not sick, like when you need immunization shots. It is important to see your PCP doctor even when you are not sick!
- Sick care. These visits are when you see your PCP doctor because you are not feeling well.

When you need a checkup or if you get sick, you need to go to your PCP doctor. Call your PCP doctor. The phone number is on your ID card.

Start getting care now! Call your PCP doctor for a checkup.

It is important for new members to get a checkup even if they are not sick. Be sure to schedule a checkup soon after becoming an L.A. Care/Anthem Blue Cross member. Call your PCP doctor today to make an appointment for a “new member checkup.” This visit is also called a “well visit” or “initial health assessment.” Your PCP doctor’s telephone number is on your L.A. Care/Anthem Blue Cross ID card.

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

How to see your PCP doctor

1. Call your PCP doctor’s office to schedule an appointment. You should get an appointment to see your PCP doctor within 10 business days from the date of your call. Your PCP doctor’s phone number is on your L.A. Care/Anthem Blue Cross ID card.
2. Be on time for your appointment. If you need directions, call the PCP doctor’s office.

3. If you can’t go to your appointment, call the PCP doctor’s office right away. By canceling your appointment, you allow someone else to be seen by the doctor.

4. If you miss your appointment, call right away to make another appointment.

5. Show the PCP doctor’s office your ID card when you are there.

**Important! You can still get services without your ID card. If you need to see your PCP doctor, your PCP doctor (or hospital or pharmacy) can call L.A. Care or Anthem Blue Cross so you can get care.**

**How to get care when your PCP doctor’s office is closed**

If you need care when your PCP doctor’s office is closed (such as after normal business hours, on the weekends or holidays), call your PCP doctor’s office. Ask to speak to your PCP doctor or to the doctor on call. A doctor will call you back.

You can also call the nurse advice line number that is on your ID card. This number is available to you 24 hours a day, seven (7) days a week, to help answer your health care questions and have your health concerns and symptoms reviewed by a registered nurse. This service is free of charge and available to you in your language.

For urgent care (this is when a condition, illness or injury is not life-threatening, but needs medical care right away), call or go to your nearest urgent care center. Many of Anthem Blue Cross’ doctors have urgent care hours in the evening, on weekends or during holidays.

**If you get a bill**

Anthem Blue Cross pays for all covered medical costs approved by your PCP doctor or for an emergency. You should not get a bill for any services covered by Anthem Blue Cross. Please call Anthem Blue Cross or L.A. Care right away if you receive a medical bill. Anthem Blue Cross or L.A. Care will make sure the doctor stops sending you a bill.

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

You should not be billed for emergency care, urgent care, the care required to stabilize an emergency condition, family planning services, or for sexually transmitted disease testing at a clinic. You should not be billed for hospital care you get right after an emergency. If you receive a bill, do not pay it. Call Anthem Blue Cross or L.A. Care right away to take care of the bill for you.

Do not pay medical bills you get from a collection company. If you get a bill for covered services and need help or if you want to file a complaint, call Member Services at L.A. Care Health Plan or Anthem Blue Cross. When your doctor receives proof that you had Medi-Cal at the time of your visit, your doctor must let the collection company know you had Medi-Cal at that time. If you had Medi-Cal at the time of your doctor visit, you cannot be charged for covered medical services. Your doctor must tell the collection company to stop trying to make you pay the bill. The doctor may have to pay up to three (3) times what is owed if he/she does not tell the collection company to stop trying to make you pay the bill. If you get a bad credit report because of an unpaid medical bill for covered services, the doctor has up to 30 days from the
What is a second opinion?

You have the right to ask for and get a second opinion at no cost to you. You also have the right to ask for a timely response to your request for a second opinion. A second opinion is a visit with another doctor when:

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

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

If there is no qualified health care professional within Anthem Blue Cross’ network, then Anthem Blue Cross will authorize (or okay) a second opinion by a qualified health care professional outside Anthem Blue Cross’ network.

How to get a second opinion

To get a second opinion:

1. Talk to your PCP doctor, specialist or Anthem Blue Cross and let them know you would like to see another doctor and the reason why.

2. Your PCP doctor, specialist or Anthem Blue Cross will refer you to a qualified health care professional. If you are requesting a second opinion about a diagnosis that your PCP doctor made, the second opinion shall be from a PCP doctor of your choice from the same physician organization as your PCP doctor’s. If you are requesting a second opinion about a diagnosis that your specialist made, a second opinion must come from any independent physician association (IPA) or medical group within the network for the same specialty. If there is no qualified health care professional within your plan’s network, Anthem Blue Cross will authorize (or okay) a second opinion by a qualified provider outside the network.

3. Call the second opinion doctor to make an appointment.

4. Show the doctor’s office your ID card.

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

Are you pregnant? Call Anthem Blue Cross at 1-888-285-7801

Call your health plan right away if you are pregnant or become pregnant. This is because we want you and your baby to be healthy. Then, call your PCP doctor or OB/GYN to make an appointment. You should get an appointment to see your PCP doctor or OB/GYN within 14 calendar days from the date of your call. When you are pregnant, it is important to get care right away, throughout your pregnancy, and after you give birth.
How to get health care that your PCP doctor can’t give you

Sometimes you need care your PCP doctor can’t give you. You may need care from a specialist or a hospital. To see a specialist or for treatment at a hospital, your PCP doctor must authorize (or okay) the care, and give you a “referral.” A referral is a request from your PCP doctor to another doctor or to the hospital for health care services or treatment you may need. Your PCP doctor will start the referral process. You MUST get a referral BEFORE you get specialized health care services or treatment at a hospital (except for emergency care, urgent care, or if you need to see an OB/GYN).

Routine referrals take up to five (5) business days to process (business days are Monday through Friday), but may take up to 10 business days if more information is needed from your PCP doctor. In some cases, your PCP doctor may ask to “rush” your referral. Expedited (rush) referrals may not take more than three (3) calendar days. Please call Anthem Blue Cross if you do not get a response by these times.

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

Emergency services anywhere or urgently needed services when outside of Los Angeles County do not need a referral.

How to get a standing referral with a specialist

You may need to see a specialist (or other qualified health care professional) for a long time if you have a condition or disease that is chronic (such as diabetes or asthma), life-threatening (such as HIV/AIDS) or disabling.

This is called a “standing referral.” A standing referral is made to a specialist who is in Anthem Blue Cross’ network or who is with a contracted specialty care center. If Anthem Blue Cross does not have a qualified specialist, Anthem Blue Cross will send you to a specialist outside their network.

A standing referral needs an approval by Anthem Blue Cross. You can ask your PCP doctor for a standing referral. Or, your doctor can ask Anthem Blue Cross for a standing referral. Anthem Blue Cross must decide on your request for a standing referral within three (3) business days. Once you have a standing referral, you will not need permission for each visit with the specialist.

Your specialist will develop a treatment plan for you. The treatment plan will show how often you need to go to the doctor. Once the treatment plan is approved, the specialist will coordinate the care you get. This specialist will be authorized to provide health care services the same way your PCP doctor would, based on his or her skill, training and the treatment plan.
ID Cards: How do I use them?

What to do with your L.A. Care/Anthem Blue Cross ID card

Along with this handbook, you received an L.A. Care/Anthem Blue Cross ID card for every family member covered by Medi-Cal. If you did not receive an ID card for a family member who is covered by Medi-Cal, call Anthem Blue Cross right away.

Your L.A. Care/Anthem Blue Cross ID card has important information on it, including:

- Your PCP doctor’s name (or the name of your clinic or medical group)
- Your PCP doctor’s phone number
- The 24-hour nurse advice line and member services phone numbers

Here’s what to do with your ID card:

- Check to make sure the information on your ID card is correct. Is your name spelled right? Is your birth date right? If anything on your ID card is wrong, call Anthem Blue Cross at Anthem Blue Cross right away. Anthem Blue Cross will connect you to the California Department of Public Social Services (DPSS), toll-free at 1-877-481-1044, to get it fixed.
- Keep your ID card in a safe place. If you lose or damage your ID card, call Anthem Blue Cross at 1-888-285-7801.
- Show your ID card whenever you:
  - Have a doctor’s appointment
  - Go to the hospital
  - Need emergency services
  - Pick up a prescription

What to do with your Medi-Cal card (also known as BIC card)

The State of California sent you another ID card, your Medi-Cal Benefits Identification Card (also called a BIC card). You need to show your Medi-Cal card whenever you get services you don’t get from L.A. Care/Anthem Blue Cross. You can learn more about these services in the “More benefits: What other services can I get?” section of this handbook. Call the California Department of Public Social Services (DPSS), toll-free at 1-877-481-1044 if you need a new Medi-Cal card.

Never let anyone use your health plan ID card or Medi-Cal card. This is called fraud. You can lose your Medi-Cal benefits if someone else uses your ID cards to get care. If you lose your Medi-Cal benefits, L.A. Care/Anthem Blue Cross will not be able to give you care.
Our provider network: Who gives me health care?

Please read the following information so you will know from whom or what group of providers you can get health care.

Anthem Blue Cross works with a large group of doctors, specialists, pharmacies, hospitals and other health care providers. This group is called a “network.” You can get a copy of Anthem Blue Cross’ network by calling Anthem Blue Cross and asking for a provider directory.

In most cases, you need to get care within Anthem Blue Cross’ network. That is not the case if you need emergency care or need urgent care outside of Los Angeles County. You can learn more about this in the “Emergency care: How do I get care in an emergency?” section of this handbook.

Your PCP doctor gives you most of your care

Your PCP doctor is responsible for making sure you get the health care benefits you need and should receive from Medi-Cal.

How to change your PCP doctor

If you didn’t choose a PCP doctor when you enrolled in Medi-Cal, a PCP doctor was chosen for you by L.A. Care. Your PCP doctor was chosen for you based on:

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

It is best to stay with the same PCP doctor. Your PCP doctor gets to know your health history and health needs. If you can’t stay with the same PCP doctor, you can choose a new one from the Anthem Blue Cross network shown in the provider directory mailed to you with this handbook. Call Anthem Blue Cross for another copy of the provider directory or to help you choose another PCP doctor.

You can change your PCP doctor for any reason if you are not happy. To change your PCP doctor, call Anthem Blue Cross. You may choose a PCP doctor within the first 30 calendar days of enrollment and change at least monthly after that.

Things to remember if you choose a new PCP doctor:

- Some doctors work within a group of doctors with certain specialists, hospitals and other health care providers. If you need a specialist, your PCP doctor may send you to these providers. If you are going to a specialist already or want to use a specific hospital, talk with the PCP doctor you are choosing.
- A PCP is a doctor or even a clinic. You can pick one PCP doctor for all members of your family in Medi-Cal or you can pick a different PCP doctor for each member of your family in Medi-Cal. Women may choose an OB/GYN or family planning clinic as their PCP doctor.
- Ask about office access if you or a family member has a disability.

The PCP doctor you choose may not agree to treat you and may ask L.A. Care to make a change. This can happen if:

- You are disruptive or disrespectful to your doctor or your doctor’s office staff.
- You do not follow your doctor’s treatment plan.
• The service or care you need is not within the doctor’s scope of care (like a high-risk pregnancy).

Kinds of PCP doctors
You can choose your PCP doctor from the Anthem Blue Cross provider directory that came with this handbook. The kinds of physicians that can be PCP doctors are:

• Family Practice
• General Practice
• Internal Medicine
• Pediatricians
• OB/GYN (for female members only)

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

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

If a hospital or other provider tells you that it has a moral objection to providing you with these services, you should call Anthem Blue Cross’ Customer Care Center to ensure you can get the health care services you need.

Choosing a Federally Qualified Health Center as your PCP doctor
A Federally Qualified Health Center (FQHC) is a clinic and can be your PCP doctor. FQHCs get money from the federal government because they are located in areas without a lot of health care services. Call Anthem Blue Cross for the names and addresses of the FQHCs that work with Anthem Blue Cross or look in the provider directory mailed to you with this handbook.

How to get care from a specialist
Your PCP doctor is the doctor who makes sure you get the care you need when you need it. Sometimes your PCP doctor will send you to a specialist. A “specialist” is a doctor who is an expert in a certain kind of health care. These specialists are within your PCP doctor and Anthem Blue Cross’ network. If you need care from a specialist, your PCP doctor must approve these services before you receive them. Routine referrals to a specialist take up to five (5) business days and rush referrals (for when you need medical care right away or have an urgent condition) can’t take more than three (3) calendar days.

Female members who need OB/GYN care don’t need their PCP doctor’s okay to go to an OB/GYN or family planning doctor with Anthem Blue Cross.

Our doctors’ professional qualifications
We are proud of our doctors and their professional training. If you have questions about the professional qualifications of network doctors and specialists, call Anthem Blue Cross. Anthem Blue Cross can tell you about their medical training or qualifications.
Certified Nurse Midwives
Certified Nurse Midwife services are available outside of Anthem Blue Cross’ network. Members may see a Certified Nurse Midwife without a PCP doctor’s okay. To find out more, ask your PCP doctor or call Anthem Blue Cross.

Certified Nurse Practitioners
Some PCP doctors who work with Anthem Blue Cross have Certified Nurse Practitioners on staff to see patients. Members may see a Certified Nurse Practitioner. To see a Certified Nurse Practitioner or for more information, ask your PCP doctor or call Anthem Blue Cross.

What care can you get from a provider who is not your PCP doctor?
There are some kinds of care that you can get from someone other than your PCP doctor:

- Emergency care. In an emergency, dial 911. Emergency services do not need a referral or an okay from your PCP doctor or Anthem Blue Cross before you get them.
- Urgent care when you are not in Los Angeles County and can’t come back to Los Angeles County to get care. Call your PCP doctor if you are not sure how to get urgent care when you are not in Los Angeles County. Your PCP doctor or your doctor’s office will help you.
- Family planning services and sexually transmitted disease testing. You may get these services from any health care provider licensed to provide these services. You do not need your PCP doctor’s okay to get these services.
- Specialist care. A “specialist” is a type of doctor who is an expert in a certain kind of health care. Your PCP doctor will send you to a specialist if you need one. In most cases, you can’t see a specialist without your PCP doctor’s okay.
- Members may see an in-network OB/GYN for OB/GYN services without the PCP doctor’s okay.

How to keep seeing your doctor if your doctor leaves your health plan
Sometimes Anthem Blue Cross stops working with a doctor or hospital. If this happens, we will let you know as soon as we can. You can ask to keep seeing your doctor (including specialists and hospitals) if that doctor agrees and has been treating you for any of the following conditions:

- An acute condition (a serious and sudden condition that lasts a short time like a heart attack, pneumonia or appendicitis) – for the time the condition lasts.
- A serious chronic (long-term) condition – for a period of time necessary to complete a course of treatment and arrange for a safe transfer to another provider.
- A pregnancy – during the pregnancy and immediate postpartum care (6 weeks after giving birth).
- A terminal illness/condition – for the length of the illness/condition.
- Children from 0 to 36 months – for up to 12 months.
- A surgery or other procedure authorized by Anthem Blue Cross as part of a documented course of treatment. This treatment was set to occur within 180 calendar days of the time the doctor or hospital stops working with Anthem Blue Cross or within 180 calendar days of the time you began coverage with Anthem Blue Cross.
How to keep seeing your doctor if you are a new member

Members who have just joined L.A. Care and Anthem Blue Cross may ask to keep seeing their doctor or hospital if they are in the middle of treatment or have scheduled treatments or procedures. This is called a “continuity of care” benefit.

You will not be eligible for the continuity of care benefit if EITHER:

- You are a new enrollee with Anthem Blue Cross and were offered an opportunity from your previous health plan to continue receiving care from an out-of-network provider; OR
- You had the option to continue care from your previous provider but still chose to change health plans.

Doctors not contracted with Anthem Blue Cross may be required to agree to the same terms and conditions as contracted providers. If the doctor does not agree, Anthem Blue Cross is not required to provide the services through that doctor.

You can get a copy of Anthem Blue Cross’ continuity of care policy by calling 1-888-285-7801. Please call Anthem Blue Cross and ask how to request “continuity of care.”

Care outside of Anthem Blue Cross’ network

As a member of Anthem Blue Cross, your service area is Los Angeles County. For routine (regular) care, all health care services are provided in Los Angeles County. Routine care outside of L.A. County is not covered.

In most cases, you need to get care within Anthem Blue Cross’ network and within Los Angeles County. However, you can always get emergency care or urgent care anywhere.

If you get care from a non-contracted provider (a doctor or other provider that is not a part of Anthem Blue Cross’ network) or outside of Los Angeles County, you may be billed by the provider and you may have to pay, except for emergency care, urgent care, family planning, and for sexually transmitted disease (STD) testing services. You can learn more about this in the "Emergency care: How do I get care in an emergency?" section of this handbook.
What is covered: What kinds of health care can I get from Anthem Blue Cross?

In order for you to get any health care service through Anthem Blue Cross, the service must be both:

- A covered benefit in Medi-Cal; and
- Medically necessary.

A “covered benefit” means that you can get this service through Medi-Cal and Anthem Blue Cross. “Medically necessary” means that you need the service to get healthy or stay healthy.

All health care services are reviewed, modified (changed), approved or denied according to medical necessity. If you would like a copy of the policies and procedures Anthem Blue Cross uses to decide if a service is medically necessary, call Anthem Blue Cross. No doctor has to give you services that he/she doesn’t believe you need. Services are subject to all terms, conditions, limits and exclusions. You can learn more about this in the “Non-covered Services: What does Medi-Cal not cover?” section of this handbook.

All services require prior authorization unless the benefit says that it does not require prior authorization. “Prior authorization” means that your PCP doctor and Anthem Blue Cross agree that services and care are necessary. You must have a prior authorization before you get services or care, such as services from a specialist.

Services that do not require prior authorization are:

- PCP doctor visits
- Emergency services
- Urgently needed services when outside of

Los Angeles County
- Family planning services
- Preventive services
- Sexually transmitted disease (STD) services
- HIV testing
- Basic prenatal care from a doctor who works with Anthem Blue Cross
- In-network Certified Nurse Midwife/OB/GYN

Call Anthem Blue Cross at 1-888-285-7801 if you have questions about:

- Your benefits
- How or where to get benefits
- What is covered or not covered

All covered benefits are free.

Covered benefits:

Alcohol/drug abuse
- Crisis intervention
- Health education services

Asthma services
- Nebulizers (including face mask and tubing), inhaler spacers and peak flow meters for management and treatment of asthma
- Member education on proper use of nebulizers, inhaler spacers and peak flow meters for asthma

Cancer screening
- All generally medically accepted cancer screening tests, including coverage for screening and diagnosis of prostate cancer
• Mammography for breast cancer screening
• Cervical cancer screening test, including:
  • Human papillomavirus (HPV) screening
  • HPV vaccinations including, but not limited to, Gardasil® for girls and young women ages 9 through 26
• Cancer clinical trials. If you have cancer, you may be able to be part of a cancer clinical trial. A cancer clinical trial is a research study with cancer patients to find out if a new cancer treatment or drug is safe and treats a member’s type of cancer. The cancer clinical trial must meet certain requirements, when referred by your Anthem Blue Cross doctor or treating provider. It must have a meaningful potential to benefit you and must be approved by one of the following: the National Institute of Health (NIH), the Food and Drug Administration (FDA), the U.S. Department of Defense or the U.S. Veteran’s Administration. If you are part of an approved cancer clinical trial, Anthem Blue Cross will provide coverage for all routine patient care costs related to the clinical trial.

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

**Diabetic services**
These services are covered for diabetics when medically necessary:
• Medical equipment
• Prescription drugs
• Diabetes-related supplies:
  • Blood glucose monitors and testing strips
  • Blood glucose monitors designed to assist the visually impaired for insulin dependent, non-insulin dependent and gestational diabetes
  • Insulin pumps and all related necessary supplies
  • Ketone urine testing strips
  • Lancets and lancet puncture devices
  • Pen delivery systems for the administration of insulin
  • Podiatric devices of the feet (such as special footwear or shoe inserts) to prevent or treat diabetes-related complications
  • Insulin syringes
  • Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
• Training and health education for self management
• Family education for self-management

**Doctor’s office visits**
• All routine visits, exams, treatments, required immunization shots, and Child Health Disability Prevention Program (CHDP) visits are provided by your doctor.
• Services from a specialist.
• Any CHDP services from school-based programs or the Los Angeles County Department of Health Services. There is more information about CHDP services under the “More benefits: What other services can I get?” section of this handbook. You can also call CHDP at 1-800-993-2437.
Drugs/medications

Prescription drugs and over-the-counter drugs on the Anthem Blue Cross formulary are covered. You can learn more about this in the “Pharmacy benefits: How do I get prescription drugs?” section of this handbook.

Durable medical equipment (DME)

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

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

Emergency services

Emergency services are covered 24 hours a day, seven (7) days a week, anywhere. Emergency care is a service that a member reasonably believes is necessary to stop or relieve:

- Sudden serious illnesses or symptoms
- Injury or conditions requiring immediate diagnosis and treatment

Emergency services and care include ambulance, medical screening, examination, and evaluation by a doctor or appropriate personnel. Emergency services include both physical and psychiatric emergency conditions, and active labor. You can learn more about these in the “Emergency care: How do I get care in an emergency?” section of this handbook.

Family planning

Family planning services are provided to members of child-bearing age to help them choose the number and spacing of children. These services include all methods of birth control approved by the Food and Drug Administration (FDA). You may receive family planning services and FDA-approved contraceptives from any health care provider licensed to provide these services.

Examples of family planning providers include:

- Your PCP doctor
- Clinics
- Certified Nurse Midwives and Certified Nurse Practitioners
- OB/GYN specialists (doctors who specialize in female reproductive health care)
- Planned Parenthood clinics

Family planning services also include counseling and surgical procedures for the termination of pregnancy (called an abortion). Please call Anthem Blue Cross to find out more.

Many of our doctors who provide family planning services are also OB/GYN specialists. Women may pick a PCP doctor from a list of family planning clinics located near them. Call Anthem Blue Cross for a copy of this list.

Women have the right to family planning services given by a family planning provider who is not in

Anthem Blue Cross Customer Care Center toll-free 1-888-285-7801
L.A. Care Health Plan Member Services Department toll-free 1-888-839-9909
Anthem Blue Cross’ network. You do not need an okay from your PCP doctor to do this. Anthem Blue Cross will pay that doctor or clinic for the family planning services you get.

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

**Health education services**
Anthem Blue Cross has health education materials, programs and services to help you stay healthy and take care of yourself. These programs are free. Health education services can help members by:

- Promoting health: Learn to develop life-long healthy habits.
- Preventing diseases: Learn how to prevent and care for life-threatening illnesses.
- Helping them manage chronic diseases.

Learn more about these topics by talking to your doctor or through health education services:

- Asthma
- Diabetes
- Dental Health
- Drug and Alcohol Programs
- Family Planning/Birth Control
- HIV
- Healthy Foods
- High Blood Pressure
- Immunization (Shots)
- Parenting/Child Health
- Prenatal Health
- Safety Tips
- Sexually Transmitted Diseases (STDs)
- Tobacco Use (how to quit or prevent smoking)
- Violence Abuse
- Weight Problems

Health education services include:

- Written materials (booklets)
- Tapes, DVDs, CDs or videos
- Referrals to health education classes or programs
- Counseling (one-on-one teaching, phone or group)
- Support groups
- Online community resource and health education information

For health education services information, visit L.A. Care online at [lacare.org](http://lacare.org). You can also visit Anthem Blue Cross website at [anthem.com/ca](http://anthem.com/ca) for information.

Ask your doctor for health education materials and classes. You can also call L.A. Care/Anthem Blue Cross.

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

**HIV testing**
You can get confidential HIV testing from any health care provider licensed to provide these services. You do not need a referral or okay from your PCP doctor or health plan for confidential
HIV testing. Examples of where you can get confidential HIV testing include:

- Your PCP doctor
- Los Angeles County Department of Health Services
- Family planning services providers
- Prenatal clinics

Please call Anthem Blue Cross to request a list of testing sites.

**Home health**

These services are provided in the home by health care personnel for all of the following:

- Short-term physical, occupational, and speech therapy
- Respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her license

Home health services ordered by your doctor are provided by home health personnel such as:

- Registered Nurses (RNs)
- Licensed Vocational Nurses (LVNs)
- Home Health Aides
- Medical Social Services

If a service can be provided in more than one location, Anthem Blue Cross will work with the provider to choose the location.

**Hospice care**

Care is limited to terminally ill members expected to live 12 months or less. If you decide to receive hospice benefits, you are waiving all rights to all other benefits for the terminal illness for the duration of the hospice election. The hospice election may be made of up to two (2) periods of 90 days each, one subsequent period of 30 days, and one 180-day extension of the 30-day period. Hospice services are not covered for more than 390 days.

**Hospital care**

Includes, but is not limited to:

- Inpatient services
- Intensive care
- Outpatient services

**Incontinent creams and washes**

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

**Lab services**

- Blood work
- Urine tests
- Throat cultures

Services must be provided at a network:

- Doctor’s office
- Hospital
- Laboratory

**Mastectomy**

Mastectomy is a surgery to remove a breast, due to cancer.

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

You and your doctor decide how long you need to stay in the hospital after the surgery based on medical necessity.
Maternity care
Maternity care includes:

- Regular doctor visits during your pregnancy (called prenatal visits)
- Diagnostic and genetic testing
- Nutrition counseling
- Labor and delivery care
- Health care six (6) weeks after delivery (called postpartum care)
- Inpatient hospital care for at least 48 hours after normal vaginal deliveries or for at least 96 hours after a Cesarean section. Coverage for inpatient hospital care may be less than 48 hours or 96 hours if:
  - The decision is made by the mother and treating physician, and
  - A post-discharge follow-up visit for the mother and newborn is made within 48 hours of discharge.

If you are pregnant, call Anthem Blue Cross at 1-888-285-7801 right away. We want to make sure you get the care you need. Anthem Blue Cross will help you choose your maternity care doctor from a doctor in your network. Ask your doctor to find out more.

After giving birth, you will receive breastfeeding education and special equipment if needed. Ask your doctor, or call Anthem Blue Cross if you have any questions.

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

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

The following services are covered:

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

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

When you have a baby, it is important to do three (3) things:

1. Please call L.A. Care at 1-888-839-9909. We want to make sure you and your baby get the care you need right away.
2. Contact your eligibility worker at DPSS toll-free at 1-877-481-1044 to enroll your
baby in Medi-Cal. **This is important so that your baby can continue to get Medi-Cal benefits!**

3. **Take your baby to the doctor within three (3) days of getting home from the hospital after delivery.** An Anthem Blue Cross doctor in your network should see your newborn baby within a few days of the birth. Call Anthem Blue Cross for more information on getting an appointment.

Newborn baby screenings for certain treatable genetic disorders are covered. These genetic disorders include:

- Phenylketonuria (PKU)
- Galactosemia
- Hypothyroidism
- Hemoglobinopathies
- Sickle cell disease
- Thalassemia
- Amino acid disorders
- Organic acid oxidation disorders
- Fatty acid oxidation disorders
- Congenital adrenal hyperplasia (CAH)
- Related blood disorders

Babies with these conditions will be referred to California Children’s Services (CCS) for treatment or to Anthem Blue Cross if the treatment is not covered by CCS.

Treatment of PKU includes medically prescribed formulas and special food products. PKU cases are followed by a health care professional who consults with a doctor specializing in PKU-related diseases. You can learn more about this in the “More benefits: What other services can I get?” section of this handbook.

**Obstetrical/Gynecological (OB/GYN)**

Pregnant members do not need a referral or okay from their PCP doctor or Anthem Blue Cross to see an OB/GYN who works in their network. Please call Anthem Blue Cross if you have any questions.

**Podiatry (services for the feet)**

Podiatry services are limited and require prior authorization except when received on an emergency basis.

**Prenatal care**

- Regular doctor visits during your pregnancy (called prenatal visits)
- Prenatal supplements
- Diagnostic and genetic testing

**Reconstructive surgery**

Reconstructive surgery to repair abnormal body parts, improve body function or bring back a normal look.

**Sexually transmitted disease (STD) Services**

STD services include:

- Preventive care
- Screening
- Testing
- Diagnosis
- Counseling
- Treatment
- Follow-up
You can get confidential STD services from any doctor or clinic. You do not need a referral or okay from your doctor.

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

If you need long-term skilled nursing facility services, you may be disenrolled from L.A. Care and provided these services through Medi-Cal or another state program.

**Temporomandibular joint disease**
A disease of the temporomandibular joint (TMJ) that connects the lower jaw to the skull. TMJ disease is covered only for medically necessary surgery or treatment to realign the jaw, and not for a dental disorder.

**Therapy – occupational, physical and speech**
- Occupational therapy is used to improve and maintain a patient’s daily living skills because of a disability or injury.
- Physical therapy uses exercise to improve and maintain a patient’s ability to function after an illness or injury.
- Speech therapy is used to treat speech problems.

**Topical fluoride varnish**
Topical fluoride varnish helps prevent and control tooth decay. Topical application of fluoride is a Medi-Cal benefit for children younger than 6 years of age, up to three times in a 12-month period.

**Transportation**

**Emergency transportation** for a member that believes it is necessary to stop or relieve sudden serious illnesses or symptoms, or injury or conditions requiring immediate diagnosis and treatment. Emergency transportation (ambulance) or ambulance transport services provided through the "911" emergency response system will be covered in a medical emergency when medically necessary.

**Non-emergency medical transportation** to medical facilities is covered when your medical and physical condition does not allow you to take regular means of public or private transportation (car, bus, etc) and you have a written prescription from your doctor. Examples of non-emergency medical transportation include, but are not limited to, litter vans and wheelchair vans. Also includes non-emergency transportation for the transfer of a member from a hospital to another hospital or facility, or facility to home when the transportation is:

- Medically necessary, and
- Requested by the PCP doctor, and
- Authorized in advance by Anthem Blue Cross.

Non-emergency medical transportation is available if the member is recovering from serious injury or medical procedure that prevents them from driving to medical appointment, they have no other form of transportation available, and the attending physician (PCP or specialist appointment is scheduled with) asserts that member requires non-emergency medical transportation to and from appointment on specified date. If you need non-emergency medical transportation, please call your PCP doctor or Anthem Blue Cross to see if you qualify for these services. You must have approval to get these services before the services are given.

**Exclusion:** Coverage for public transportation including transportation by airplane, passenger car, taxi, or other forms of public conveyance.
**Vision care**
Eye exams are covered by Anthem Blue Cross for all members under 21 years of age. You are limited to one pair of eyeglasses every two (2) years unless your prescription changes. This includes lenses and covered frames for eyeglasses when authorized. Diabetic members age 21 and older are covered for eye exams only.

To find out more about eye exams or vision care coverage call Anthem Blue Cross.

**X-ray services**
These services will be provided when ordered by your doctor from a network:
- Doctor’s office
- Hospital
- Laboratory
More benefits: What other services can I get?

Medi-Cal members are entitled to other health care benefits and services that are not provided by L.A. Care/Anthem Blue Cross.

California Children’s Services (CCS)

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

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

Please call Anthem Blue Cross if your child is getting CCS services. Anthem Blue Cross can arrange for those services to continue. Your child can continue getting services as a member of L.A. Care/Anthem Blue Cross. You can call the Los Angeles County CCS office toll-free at 1-800-288-4584 to find out more.

Child Health and Disability Prevention

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

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

Women, Infants and Children (WIC) Program

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

Special services for American Indians

American Indians have the right to get health care services at Indian Health Centers and Native American Health Clinics. American Indians may stay with or disenroll from L.A. Care/Anthem Blue Cross while getting health care services from an Indian Health Center or Native American Health Clinic. American Indians have a right to not enroll in a Medi-Cal managed care plan or may leave their health plans and return to regular (fee-for-service) Medi-Cal at any time and for any reason. Please call Indian Health Services at 1-916-930-3927 to find out more. You may visit the Indian Health Services website at ihs.gov to find out more.

Medi-Cal benefit changes

The state cut a few benefits from the Medi-Cal program. These changes only affect some adults age 21 and older who are on Medi-Cal.

These changes do not affect members less than 21 years old. Medi-Cal benefits for members less than 21 years old remain the same.

These benefits will NOT change for Medi-Cal members who are:

- Under the age of 21
• Living in a skilled nursing facility (Level A or B. This includes subacute care facilities.)

• Pregnant (If you are pregnant, you can continue to receive pregnancy-related benefits and services. You can also receive other benefits and services listed above to treat conditions that, if left untreated, might cause difficulties for the pregnancy. This includes dental exams, cleanings, and gum treatment. Dental and other benefits and services may also be available up to 60 days after the baby is born.)

• Receiving benefits through the California Children’s Services (CCS) program

• Receiving benefits through a Program of All-Inclusive Care for the Elderly

However, L.A. Care feels that five (5) benefits the state cut are important to our members and will still provide these benefits when there is a medical need.

As an L.A. Care Medi-Cal member, you will keep getting:

- Speech therapy services
- Podiatry (foot) services
- Audiology (hearing) services
- Incontinence creams and washes
- Annual optometry (eye) exam for diabetic members

Services you can get outside of your health plan

Some services are not covered by L.A. Care or Anthem Blue Cross but are still benefits. They are available through Medi-Cal or another state program. Please call L.A. Care or Anthem Blue Cross if you have any questions about getting the services below.

• Acupuncture (Limited – please see the “Medi-Cal benefit changes” section)

• Adult day health care

• Alcohol and drug treatment services (outpatient)

• Childhood lead poisoning (through the Los Angeles County Department of Health Services)

• Chiropractic services (Limited– please see the “Medi-Cal benefit changes” section)

• Direct Observed Therapy for the treatment of tuberculosis (through the Los Angeles County Department of Health Services)

• Dental Services (Limited– please see the “Medi-Cal benefit changes” section) that are normally done by a dentist, orthodontist or oral surgeon, and dental appliances. You must get Dental Services through Denti-Cal. Call toll-free at 1-800-322-6384 to learn more. Anthem Blue Cross covers dental screenings under the first health checkup and will refer members to Medi-Cal dental providers. Anthem Blue Cross covers the following when medically necessary: prescription drugs, lab services, outpatient surgical services, and inpatient services. General anesthesia for dental work is covered for members under seven (7) years of age, the developmentally disabled or when medically necessary.

• Early Start/Early Intervention. Early Start/Early Intervention is for children ages 0 to 3. If your PCP doctor tells you that your child is at risk for developmental delays, your child may be eligible for the Early Start program. Developmental delays include difficulties in
communicating, adjusting to different situations, following directions or relating to others. For more information about Early Start/Early Intervention or a referral to the Regional Center for Early Start/Early Intervention, talk to your doctor or to Anthem Blue Cross.

- Local Education Agency (LEA) assessment services are provided to students who qualify through the school system.

- Major organ transplants, except for renal or corneal transplants

- Members with developmental disabilities. Developmental disabilities include difficulty learning or difficulty with motor skills. If your PCP doctor tells you that you have a developmental disability, you may be eligible for services from the Regional Centers. For more information about or for a referral to a Regional Center, talk to your PCP doctor or call Anthem Blue Cross.

- Mental health services. Mental health services may include treatment for anxiety, behavioral health problems or depression. Your PCP doctor will provide you with some outpatient mental health services within the scope of their training and practice. Call your PCP doctor for more information about mental health services available through your PCP doctor.

- Specialized mental health services may be needed for services beyond your PCP doctor’s training and practice. These services are provided through the Los Angeles County Department of Mental Health (LACDMH). You can receive services from LACDMH with or without a referral from your doctor. LACDMH can be reached toll-free at 1-800-854-7771.

- Members with developmental disabilities. Developmental disabilities include difficulty learning or difficulty with motor skills. If your PCP doctor tells you that you have a developmental disability, you may be eligible for services from the Regional Centers. For more information about or for a referral to a Regional Center, talk to your PCP doctor or call Anthem Blue Cross.

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- Parents or guardians of a child with a developmental disability may be eligible for services through the Regional Centers. For more information about or for a referral to a Regional Center, talk to your PCP doctor or call Anthem Blue Cross.

- Mental health services. Mental health services may include treatment for anxiety, behavioral health problems or depression. Your PCP doctor will provide you with some outpatient mental health services within the scope of their training and practice. Call your PCP doctor for more information about mental health services available through your PCP doctor.

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- Specialized mental health services may be needed for services beyond your PCP doctor’s training and practice. These services are provided through the Los Angeles County Department of Mental Health (LACDMH). You can receive services from LACDMH with or without a referral from your doctor. LACDMH can be reached toll-free at 1-800-854-7771.
Non-covered services: What does Medi-Cal not cover?

The following is a list of services not covered by L.A. Care/Anthem Blue Cross or by the regular (fee-for-service) Medi-Cal program:

- All services excluded from Medi-Cal under state and/or federal law
- Routine circumcision, unless medically necessary
- Cosmetic surgery (surgery performed to alter or reshape normal structures of the body in order to improve your appearance)
- Custodial care. Some custodial care may be covered under regular (fee-for-service) Medi-Cal. For more information about custodial care covered under regular Medi-Cal, call DPSS. You can find DPSS’ phone number under the “Important Phone Numbers” section of this handbook.
- Experimental and investigational services. You can learn more about this in “IMRs for Experimental and Investigational Therapies (IMR-EIT)” under the “Complaints: What should I do if I am unhappy?” section of this handbook.
- Infertility
- Immunizations (shots) for sports, work or travel
- Personal comfort items such as phones, television and guest tray when in the hospital

The following is a list of services not covered for some L.A. Care/Anthem Blue Cross Medi-Cal members over the age of 21 (please see the “Medi-Cal benefit changes” section):

- Dental
- Chiropractic
- Acupuncture
- Psychiatry Services

If you have questions about what is covered or not covered, please call Anthem Blue Cross.
Pharmacy benefits: How do I get prescription drugs?

What is a pharmacy?
A pharmacy is a place to get your prescriptions filled. Anthem Blue Cross works with pharmacies in many neighborhoods. You must get your prescribed medications (drugs) from a pharmacy in Anthem Blue Cross’ network. A “network” is all of the pharmacies that work with Anthem Blue Cross. A pharmacy list is in the provider directory provided to you with this handbook. Or, you can call Anthem Blue Cross at 1-888-285-7801 for pharmacies in your neighborhood.

How to get a prescription filled
1. Choose a pharmacy that works with Anthem Blue Cross.
2. Bring your prescription to the pharmacy.
3. Show the pharmacy your L.A. Care/Anthem Blue Cross ID card.
4. Make sure the pharmacy knows about all medications you are taking and/or any allergies you have to any medicine.

You should not be asked to pay for covered prescription drugs. Call Anthem Blue Cross if a pharmacy asks you to pay.

Prescription refills
If you are refilling a prescription you already have, go to a pharmacy in L.A. Care’s or Anthem Blue Cross’ provider directory. Also, you may be able to receive a 90-day supply of maintenance medications at most local pharmacies. Maintenance medications are drugs that you need to take for a long time, such as pills for high blood pressure or diabetes. Please ask your doctor to write a 30-day prescription supply, as well as a 90-day supply for prescription refills to take to a local network pharmacy, for your maintenance medication(s).

What is a formulary?
Anthem Blue Cross uses a list of approved drugs called a “formulary.” A committee of Anthem Blue Cross doctors and pharmacists reviews drugs to add or remove from the formulary every three (3) months.

Drugs can be added to the formulary when they are all of the following:
- Approved by the Food and Drug Administration (FDA)
- Generally accepted to be safe and effective
- Cost effective

Your doctor usually prescribes drugs from the formulary. Your doctor will only prescribe a drug based on your health status. Just because a drug is on the formulary does not mean a doctor will prescribe it to you. Your doctor may not believe you need it.

You may call Anthem Blue Cross to ask for a copy of the formulary in your language, large print, Braille, audio, or alternate format. You may also call L.A. Care for a list that compares all health plan partner formularies.

Drugs not on the formulary
Sometimes, your doctor may need to prescribe a drug that is not on the formulary. Your doctor must call to get an okay from Anthem Blue Cross.
To decide if this drug will be covered, Anthem Blue Cross may ask your PCP doctor or the pharmacist (or both) for more information. Within 24 hours after getting this information, Anthem Blue Cross will tell your PCP doctor or the pharmacist if the drug will be covered. Your PCP doctor or the pharmacist will then tell you.

If the drug is approved, you can get the drug at a pharmacy that works with Anthem Blue Cross. If the drug is not approved, you have the right to appeal the decision. An “appeal” is when you want a decision to be reviewed. You can learn more about this in the “Complaints: What should I do if I am unhappy?” section of this handbook.

What drugs are covered?

You can get the following drugs and other items when they are prescribed by your doctor and are medically necessary:

- Prescription drugs listed on the Anthem Blue Cross formulary
- Prescription drugs you get from a pharmacy not in Anthem Blue Cross’ network when you have an emergency
- Non-prescription drugs or over-the-counter drugs (such as cough syrups, cough drops or aspirin) listed on the Anthem Blue Cross formulary
- Diabetic supplies: insulin, insulin syringes, glucose test strips, lancets and lancet puncture devices, pen delivery systems, blood glucose monitors including monitors for the visually impaired, and ketone urine testing strips
- FDA-approved birth control devices, birth control pills, diaphragms, condoms and contraceptive jellies on the Anthem Blue Cross formulary
- Emergency contraception

- EpiPens, ana-kits, peak flow meters, and spacers

What drugs are not covered?

- Drugs from a non-network pharmacy, except drugs needed because of an emergency or out-of-area care
- Non-formulary drugs, except with an okay from Anthem Blue Cross
- Drugs that are experimental or investigational in nature, except in certain cases of terminal illness. If you have been denied an experimental or investigational drug, you have the right to request an Independent Medical Review (IMR). You can learn more about this in the “Complaints: What should I do if I am unhappy?” section of this handbook.
- Cosmetic drugs, except as prescribed for medically necessary conditions
- Dietary or nutritional products, except when medically necessary or for the treatment of Phenylketonuria
- Any injectable drug that is not medically necessary and not prescribed by a doctor
- Appetite suppressants, except as medically necessary for morbid obesity
- Compounded medications with formulary alternatives or those with no FDA-approved indications
- Replacement of lost or destroyed drugs no more than two (2) times each calendar year (from January to December)

Emergency contraception (Plan B)

You may get emergency contraceptive drugs from:
- Your doctor
- A pharmacy with a prescription from your doctor, if you are younger than 17 years of age
- A pharmacy without a prescription if you are 17 years of age or older
- A pharmacy not in your health plan’s network. If this is the case, you may be asked to pay for the service. Your health plan will reimburse you for this cost.
- A local family planning clinic

Call L.A. Care or Anthem Blue Cross for a list of pharmacies that provide emergency contraceptive drugs.

**Prescription authorization process for emergencies or urgent circumstances**

Your pharmacist is authorized to dispense a 72-hour supply of medication to you if you are out of medication after an emergency room visit that did not result in hospitalization and you need to fill an emergency prescription. Your pharmacist is also authorized to dispense a 72-hour supply of medication to you if you need the medication to avoid interruption of your current or prescribed drug therapy in an emergency situation.

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

Medicare administers a federal prescription drug program called Medicare Part D. If you are a Medi-Cal beneficiary with Medicare, you will get most of your prescription drugs from Medicare. There are some prescription drugs that are not covered by Medicare but that you can get through Medi-Cal. However, if you have Medicare Part D coverage with another health plan, your pharmacy will not be able to fill your Medicare Part D prescriptions with your L.A. Care or Anthem Blue Cross Medi-Cal. Please contact your Medicare Part D plan.

Please call L.A. Care or Anthem Blue Cross for more information. To find out more about Medicare Part D and to choose a Medicare Prescription Drug Plan, call Medicare at **1-800-633-4227** or go to [medicare.gov](http://medicare.gov) on the Internet.
Emergency care: How do I get care in an emergency?

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

How to get urgent care

1. Call your PCP doctor. You may speak to an operator who answers calls for your PCP doctor’s office when closed.

2. Ask to speak to your PCP doctor or the doctor on call. Another doctor may answer your call if your PCP doctor is not available. A doctor is available by phone 24 hours a day, seven (7) days a week, and also on weekends and holidays.

3. Tell them about your condition and follow their instructions.

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

What is emergency care?

Emergency services are covered anywhere – 24 hours a day, seven (7) days a week. Emergency care is a service a member reasonably believes is necessary to stop or relieve:

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

Emergency services and care include ambulance, medical screening, examination, and evaluation by a doctor or other medical personnel. Emergency services include both physical and psychiatric emergency conditions as well as active labor.

Examples of emergencies include but are not limited to:

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

Examples of psychiatric emergency medical conditions include but are not limited to:

- Thoughts or actions about hurting yourself or someone else
- Unable to care for yourself, such as being unable to feed, shelter or dress yourself due to a mental disorder

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

Call 911 or go to the nearest emergency room if you have an emergency. Emergency care is covered at all times and in all places.

Outside of Los Angeles County?

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

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

You may need hospital care after an emergency to stabilize your condition. This is called post-stabilization care. If you do, the hospital will call Anthem Blue Cross to ask for an okay. The hospital may ask you for your Anthem Blue Cross name and phone number. Show the hospital your L.A. Care /Anthem Blue Cross ID card. If you don’t have your ID card, tell them to call L.A. Care or Anthem Blue Cross.

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

What to do after an emergency

1. Call Anthem Blue Cross within 24 hours of receiving emergency care or as soon as you can.

2. Follow the instructions of the emergency room doctor.

3. Call your PCP doctor to make an appointment for follow-up care.

How to get emergency transportation

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

Not sure you have an emergency?

If you are not sure, call your PCP doctor. Do what your PCP doctor tells you to do. Non-emergency problems may include, but are not limited to, the following: earaches, colds, the flu and sore throats. Do not call 911 for non-emergency problems. Call your PCP doctor.
Help in another language and for people with disabilities: How can I get help?

Information in other languages
You have the right to receive all member materials in any of the following languages: Spanish, Armenian, Chinese, Farsi, Khmer, Korean, Tagalog, Russian, Vietnamese and English.

Interpreters for members who don’t speak English or are hearing or speech impaired
We know doctors and other providers must understand you so that you can get the health care services you need. Laws like the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA) of 1990 protect you if you do not speak English or have a disability and need help communicating with your doctor.

Your doctor’s office, clinic or hospital can’t deny services to you because you do not speak English or have a disability. You have the right to free interpreting services including American Sign Language interpreters when getting health care service or other services that are paid for by your health plan, including after-hours interpreting services.

An interpreter is a person who helps you understand what is being said by the person who is giving you care. An interpreter also tells the other person what you said, but in the language that person understands. This allows people who speak different languages or who use sign language to talk with and understand each other. This is also more private because you are not telling your child, family member or friend to interpret for you.

If you need interpreting services
Interpreting services in your language, including American Sign Language, are free – 24 hours a day, seven (7) days a week.

You should not use children or family members as interpreters. Call Anthem Blue Cross, your doctor or L.A. Care if you need interpreting services. We will work with you and your PCP doctor to make sure you can have services in a language you understand.

California Relay Service. The California Relay Service (CRS) helps a person using a TTY to communicate by phone with a person who does not use a TTY. CRS can also help a non-TTY user call a TTY user. Trained operators take phone calls and help hearing people and non-hearing people communicate.

Statewide access for voice or TTY/TDD is 1-888-877-5379 voice (SPRINT) or 1-800-735-2922 voice (MCI). Members and providers can also dial 711 on their phones to call the California Relay Service directly.

Protection for people with disabilities
The Americans with Disabilities Act of 1990 is a law that protects people with disabilities from being treated unfairly. A disability is a physical or mental condition that totally or seriously limits a person’s ability in at least one major life activity. This law protects people who:

- Are any age, including seniors (65 years of age or older), who have disabilities
- Have disabilities such as hearing, speech or vision loss, developmental disabilities, and other types of disabilities
- May not look like they have a disability or had a disability in the past

The ADA law makes sure there are equal chances for people with disabilities in employment and in
state and local government services, including health care.

A doctor’s office, clinic or hospital can’t deny you services because you are hearing impaired or have other disabilities. Call your health plan right away if you don’t get the services you need or if services are hard to get.

Here are some telephone numbers that can help you if you have a disability or want more information about the Americans with Disabilities Act:

   ADA Information Line:
   1-800-514-0301 (Voice) or
   1-800-514-0383 (TDD)

Remember: Tell your doctor’s office if you need an interpreter, require extra time during your visit, or need help because of a disability.

Complaints

You can also file a complaint if:

- You can’t get an interpreter
- You couldn’t get information in your language
- You feel that you were denied services because of a disability

You can learn more about this in the “Complaints: What should I do if I am unhappy?” section of this handbook.
Complaints: What should I do if I am unhappy?

If you are not happy, are having problems or have questions about the service or care given to you, you have the option of letting your PCP doctor know. Your PCP doctor will be able to help you or answer your questions.

At any time, you or your Member Representative can file a grievance (or complaint) with Anthem Blue Cross or with L.A. Care. A Member Representative is a person or persons appointed by the member, via written statement, to represent them in the State of California as a healthcare proxy, trustee named in a durable power of attorney or court appointed guardian. Also known as a Personal Representative(s), a Member Representative can be a spouse, relative, friend, advocate, doctor, practitioner, or someone designated as a representative by the member under Durable Power of Attorney, or as an Executor/Administrator of Estate or as a legal/court-appointed guardian.

L.A. Care and Anthem Blue Cross can’t take away your health care benefits or do anything to hurt you in any way if you file a grievance or use any of your privacy rights in this handbook.

What is a grievance?

A grievance is a complaint that is written down and tracked. You have the right to file a grievance. You have two (2) time limits to file a grievance:

- If you receive a Notice of Action from Anthem Blue Cross, then you have 90 calendar days from the date on the notice to file a grievance with Anthem Blue Cross. A Notice of Action is a formal letter telling you that a medical service has been denied, deferred, modified or terminated. If you receive a Notice of Action it will tell you in the section about “Your Rights” that you have 90 calendar days to file a grievance.
- You can also file a grievance that is not about a Notice of Action. You must file your grievance within 180 calendar days from the day you became unhappy with the service or care given to you either by your PCP doctor, specialist, medical group, hospital, pharmacy, Anthem Blue Cross or L.A. Care.

How to file a grievance

You have many ways to file a grievance. You can do any of the following:

- Fill out a grievance form at your doctor’s office. Your PCP doctor will have grievance forms available in his or her office.
- Write or call Anthem Blue Cross.
  
  **Anthem Blue Cross**
  
  P.O. Box 9054
  Oxnard, CA 93031-0954
  1-888-285-7801
- You can also file a grievance online through the Anthem Blue Cross website at anthem.com/ca. Call Anthem Blue Cross to get a grievance form in another language or format (Braille, large print or other alternative format).
- Write, visit or call L.A. Care.

  **L.A. Care Health Plan**
  
  Member Services Department
  555 West Fifth Street
  Los Angeles, CA 90013
  1-888-839-9909
  1-213-438-5748 (fax)
You can also file a grievance online through L.A. Care’s website at lacare.org. Call L.A. Care to get a grievance form in another language or format (Braille, large print or other alternative formats).

If you receive a Notice of Action from Anthem Blue Cross, you have three (3) options on how to file a grievance:

- You have 90 calendar days from the date on the Notice of Action to file a grievance with Anthem Blue Cross.
- You can request a State Hearing regarding your Notice of Action from the Department of Social Services (DSS) within 90 calendar days.
- You can request an Independent Medical Review (IMR) regarding your Notice of Action from the Department of Managed Health Care (DMHC).
  - You can also ask for a State Fair Hearing at the same time you are filing your grievance to a Notice of Action.

Anthem Blue Cross or L.A. Care can help you fill out the grievance form over the phone or in person. Or we can send you a grievance form to fill out and send back to us.

Within five (5) calendar days of getting your grievance, Anthem Blue Cross or L.A. Care will send you a letter to let you know that we have your grievance and are working on it. Then, within 30 calendar days of getting your grievance, Anthem Blue Cross or L.A. Care will send you a letter explaining how the grievance was resolved.

Filing a grievance or requesting a State Fair Hearing does not affect your medical benefits. If you file a grievance or request a Fair Hearing, you can continue a medical service while the grievance is being resolved. To find out more about continuing a medical service, call L.A. Care.

Grievances for Medi-Cal eligibility are not processed by Anthem Blue Cross or L.A. Care. To file a grievance about Medi-Cal eligibility, call DPSS. You can find DPSS’ phone number under the “Important Phone Numbers” section of this handbook.

If you don’t agree with the outcome of your grievance

If you don’t agree with the decision made on your grievance, you can request a State Fair Hearing and file a grievance with the Department of Managed Health Care (DMHC). You can also file a grievance with DMHC if you do not hear from Anthem Blue Cross or from L.A. Care within 30 calendar days. You can also request an Independent Medical Review (IMR) with the DMHC. For more information about State Fair Hearings, go to the “State Fair Hearing” section. For information on how to file a grievance with DMHC, go to the “Contacting the Department of Managed Health Care (DMHC)” section of this handbook. For information on how to request an IMR, go to the “Independent Medical Review” section of this handbook.

How to file a grievance for urgent cases

Examples of urgent cases include:

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

In urgent cases, you can request an “expedited” (or quick) review of your grievance. You can present evidence to support your grievance; however, the time available to present this evidence is limited. A decision will be made by Anthem Blue Cross or by
L.A. Care within 72 hours from the day your grievance was received.

You have the right to request an expedited State Fair Hearing. You can request an expedited State Fair Hearing and file a grievance with Anthem Blue Cross or L.A. Care. For more information about State Fair Hearings, go to the “State Fair Hearing” section of this handbook.

You have the right to file an urgent grievance with DMHC without filing a grievance with Anthem Blue Cross or L.A. Care. For information on how to file a grievance with DMHC, go to the “Contacting the Department of Managed Health Care (DMHC)” section of this handbook.

If you don’t agree with the outcome of your grievance for urgent cases

If you don’t agree with the decision made on your grievance, you can request a State Fair Hearing and file a grievance with the Department of Managed Health Care (DMHC). You can also file a grievance with the DMHC if you do not hear from Anthem Blue Cross or from L.A. Care within 30 calendar days. You can also request an Independent Medical Review (IMR) with the DMHC. For more information about State Fair Hearings, go to the “State Fair Hearing” section.

For information on how to file a grievance with DMHC, go to the “Contacting the Department of Managed Health Care (DMHC)” section of this handbook. For information on how to request an IMR, go to the “Independent Medical Review” section of this handbook.

Independent Medical Review

You can request an Independent Medical Review (IMR) from DMHC. You have up to six (6) months from the date you get a Notice of Action from Anthem Blue Cross or from L.A. Care to file an IMR. A Notice of Action lets you know about an action by Anthem Blue Cross or by L.A. Care to delay, deny, modify or terminate a health care service or benefit. You will receive information on how to file an IMR with your notice. You may reach DMHC toll-free at 1-888-HMO-2219 or 1-888-466-2219.

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

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

When to file an Independent Medical Review

You may file an IMR if you meet the following requirements:

- Your doctor says you need a health care service because it is medically necessary, but it was denied; or
- You received urgent or emergency services determined to be necessary, but they were denied; or
- You have seen a network doctor for the diagnosis or treatment of the medical condition, even if the health care services were not recommended.
- The disputed health care service is denied, changed or delayed by Anthem Blue Cross based in whole or in part on a decision that the health care service is not medically necessary; and
- You have filed a grievance with Anthem Blue Cross and the health care service is still denied, changed, delayed or the grievance remains unresolved after 30 calendar days.
You must first go through the Anthem Blue Cross grievance process, before applying for an IMR. In special cases, DMHC will not require you to follow the Anthem Blue Cross grievance process before filing an IMR. In urgent circumstances or cases of emergency, you are not required to participate in the Anthem Blue Cross’ expedited grievance process for more than three (3) days before filing an IMR.

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

Non-urgent cases

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

Urgent cases

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

For urgent cases, the IMR decision must be made within three (3) calendar days from the time your information is received.

Examples of urgent cases include:

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

IMRs for Experimental and Investigational Therapies (IMR-EIT)

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

You can file an IMR-EIT if you meet the following requirements:

- You have a very serious condition that is life-threatening or debilitating (for example, terminal cancer).
- Your doctor must certify that:
  - The standard treatments were not or will not be effective, or
  - The standard treatments were not medically appropriate, or
  - The proposed treatment will be the most effective.
- Your doctor certifies in writing that:
  - A drug, device, procedure or other therapy is likely to work better than the standard treatment.
  - Based on two (2) medical and scientific documents, the recommended treatment is likely to work better than the standard treatment.
• You have been denied a drug, equipment, procedure or other therapy recommended or requested by your doctor.

• The treatment would normally be covered as a benefit, but Anthem Blue Cross has determined that it is experimental or investigational in nature.

To find out more, get help with the IMR or IMR-EIT process, or ask for an application form, please call Anthem Blue Cross.

You do not need to participate in L.A. Care’s or Anthem Blue Cross’ grievance process before asking for an IMR of a decision to deny coverage on the basis that the treatment is experimental or investigational in nature.

Contacting the California Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-888-285-7801 and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

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

State Fair Hearing

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

You can ask for a State Fair Hearing by calling toll-free 1-800-952-5253 (English and Spanish), or by writing to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

Expedited State Hearing

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

You can also call the DPSS Los Angeles County office toll-free at 1-877-481-1044. If you do not speak English, please stay on the line and ask for the language you speak. DPSS has staff members who speak Armenian, Chinese, Russian, Spanish, Tagalog and Vietnamese. You can also write to:

Department of Public Social Services  
State Fair Hearings Section  
P.O. Box 10280  
Glendale, CA 91209

Ombudsman Office

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

Arbitration: Solving problems without going to court

L.A. Care knows that some members wish to get health care services from a health plan that uses arbitration. When you choose arbitration, you give up the right to have your problem settled by a judge or jury. Many view arbitration as cheaper, quicker and better than the courts.

During arbitration, a neutral (fair and unbiased) arbitrator will listen to everyone and make a decision. You and your doctor or health plan must follow that decision. That is why the process is often called “binding” arbitration.

The party that does not win will pay for the costs unless the arbitrator decides otherwise. That being said, the winning party will **never** be responsible for more than legal fees and costs or more than one-half of the costs.

L.A. Care or Anthem Blue Cross, if they offer arbitration, can pay some or all of the fees and expenses of the arbitrator in cases of great financial hardship. Please contact L.A. Care or Anthem Blue Cross for information and an application. Arbitration does not apply to claims or disputes about alleged medical malpractice.

Anthem Blue Cross requires binding arbitration to settle all problems, including claims of medical malpractice.

**Voluntary mediation**

You can ask for mediation to resolve a grievance. An independent third person will resolve your grievance. This person is not related to L.A. Care or Anthem Blue Cross. You and L.A. Care or Anthem Blue Cross must agree to use the mediation process. You can ask for mediation, but L.A. Care or Anthem Blue Cross can decline your request. You can still file a grievance with DMHC even if you use mediation. You do not need to participate in L.A. Care/Anthem Blue Cross’ mediation process for any longer than 30 days prior to submitting a grievance to DMHC. To request mediation, call L.A. Care or Anthem Blue Cross.
Confidentiality: What are my privacy rights?

You have the right to keep your medical records confidential. That means that only people who need to see your records in order for you to get good health care will see them. You can request a copy of our Notice of Privacy Practices (NOPP). Just call Anthem Blue Cross or L.A. Care. An NOPP is provided to you in this handbook. If you would like another copy of this information, call Anthem Blue Cross or L.A. Care. The NOPP is also available on Anthem Blue Cross’ website at anthem.com/ca or on L.A. Care’s website at lacare.org.

Health information privacy

We want you to know the things that L.A. Care and Anthem Blue Cross do to keep health information about you and your family private. To keep health information about you and your family private, L.A. Care and Anthem Blue Cross:

- Handle health information the same way, every time
- Review the way health information is handled
- Follow all laws about the privacy and confidentiality of health information

All L.A. Care/Anthem Blue Cross employees with access to your health information are trained on privacy and information security laws. They also follow L.A. Care/Anthem Blue Cross rules on how to take care of your health information so it stays private. They follow L.A. Care/Anthem Blue Cross policies and procedures to protect conversations about you as well as written and electronic documents that contain protected health information about you. Employees even sign a note that promises they will keep all health information private. For example, employees are not allowed to speak about your information in elevators or hallways. Employees must also protect any written or electronic documents containing your health information across the organization. Employees have access only to the amount of information needed to do their job.

L.A. Care/Anthem Blue Cross’ computer systems protect your electronic health information at all times by using various levels of password protection and software technology. L.A. Care/Anthem Blue Cross does not give out health information to anyone or any group that does not have a right to the information by law.

L.A. Care and Anthem Blue Cross need information about you so that we can give you good health care services. The routine collection, use and disclosure of your protected health information and other kinds of private information include:

- Name
- Gender
- Date of birth
- Language you speak
- Home address
- Home or work telephone number
- Employer and occupation
- Whether you are married or single
- Health history

L.A. Care does not have complete copies of your medical records. We may get this information from you or any of these other sources:

- A parent, guardian or conservator
- Another health plan
- Your doctor
- Your application for the health care program
- Your health records
- The California Department of Health Care Services
Before L.A. Care or Anthem Blue Cross gives your health information to someone else or another group, we need your approval in writing. However, there are times when we don’t have to get your approval in writing. This may happen when:

- A court, arbitrator or similar agency needs your health information.
- A subpoena or search warrant is requested.
- A coroner needs your health information.
- Your health information is needed by law.
- Your health information is needed for treatment, payment or for health care operations.

We may give your health information to another health plan to:

- Make a diagnosis or give treatment
- Make a payment for your health care
- Review the quality of your health care

Sometimes, we may also give your health information to:

- Groups who license health care providers
- Public agencies
- Investigators
- Probate courts
- Organ donation groups
- Federal or state agencies as required by law
- Disease management programs
- Other health plans or providers involved in your care

Please note that we won’t tell anyone the results from any genetic testing.

If you have any questions, would like to know more about the privacy, information security and confidentiality of your health information, please call L.A. Care’s Member Services to reach the Privacy & Information Security Officer at 1-888-839-9909.

You can also get more information about privacy, information security and confidentiality of your health information, or how to access your health information by visiting L.A. Care online at lacare.org, or by visiting Anthem Blue Cross online at anthem.com/ca.

If you believe that your privacy has not been protected, you have the right to complain. You can file a grievance (complaint) by contacting L.A. Care Member Services and asking to speak with the Privacy & Information Security Officer at 1-888-839-9909, or you can contact the Department of Health Care Services (DHCS) at 1-916-255-5259, TTY at 1-877-735-2929, or the U.S. Office of Civil Rights 1-866-627-7748, TTY 1-866-788-4989. These phone numbers are available to you 24 hours a day, seven (7) days a week. All calls are confidential. All calls are free except for 1-916-255-5259.

Protect yourself from identity theft

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

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

Fraud
Fraud includes, but is not limited to, using someone else’s medical benefits for your health care services, using someone else’s social security number to qualify for government assistance or billing from the doctor for services that did not occur. If you commit fraud you may lose your Medi-Cal coverage.

Waste
Waste is the planned use, throwing away, or spending of health care or government resources in an unwise and wrong manner. Examples of waste include:

- Prescribing more medication than is medically necessary
- Providing health care services more than is medically necessary

Abuse
Abuse is the planned misuse of health care or government resources. Examples of abuse include:

- Requesting and obtaining medications or medical equipment you do not need to use for your benefit
- Billing from the doctor for services that did not occur

How to report fraud, waste and abuse
If you suspect someone of using your information or committing fraud, waste or abuse, please call L.A. Care’s Compliance Helpline at 1-800-400-4889. This number is available 24 hours a day, seven (7) days a week.

You can also call L.A. Care’s Member Services and ask to speak with the Compliance Officer at 1-888-839-9909, or you could call the Department of Health Care Services Fraud & Abuse Hotline at 1-800-822-6222 or the Department of Justice Office of the Attorney General Bureau of Medi-Cal Fraud & Elder Abuse at 1-800-722-0432. Your call is free and confidential.

Why should you care about fraud, waste and abuse?
Health care fraud, waste and abuse are serious issues. Fraudulently received benefits or services impact the cost of your health care services. The cost of health care impacts the benefits available to you.

Preventing health care fraud
Here are a few helpful tips on how you can help prevent health care fraud:

- Do not give your ID card or ID card number to anyone except your doctor, clinic, hospital, health care provider or health plan.
- Do not let anyone borrow your ID card.
- Never sign a blank insurance claim form.
- Never loan your social security card to anyone.
- Beware of anyone who offers you free medical services in exchange for your ID card. You should never give away your ID card to anyone in exchange for free medical services.
- If it sounds too good to be true, it probably is. Be careful about accepting medical services in addition to Medi-Cal when you are told they will be free of charge.
Medi-Cal: How can I make sure I don’t lose my coverage?

Keeping your Medi-Cal eligibility

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

If you lose Medi-Cal eligibility, you will not be able to keep your Medi-Cal benefits with L.A. Care/Anthem Blue Cross.

Be sure to fill out and return any information requested before the due date on the letter or form. If you have any questions about your Medi-Cal eligibility, call your eligibility worker or the Department of Public and Social Services (DPSS) toll-free at 1-877-481-1044.

If you move, you must tell us!

Don’t lose your Medi-Cal coverage if you move! DPSS must have your address so they can send you mail to renew and stay eligible.

If you move but still live in Los Angeles County, please:

1. Call your eligibility worker at DPSS right away at 1-877-481-1044; and
2. Call L.A. Care or Anthem Blue Cross. We need to know your new address and phone number.

If you move outside of Los Angeles County but still live in California, call your eligibility worker at DPSS right away toll-free at 1-877-481-1044. Your eligibility worker can help you find out what Medi-Cal services are available in your new community.

Two types of Medi-Cal

There are two types of Medi-Cal in Los Angeles County: “fee-for-service” and “managed care.” In Los Angeles County, most Medi-Cal members are in “managed care.” L.A. Care and Anthem Blue Cross are managed care health plans.

“Managed care” is when your health care is managed and coordinated by a health plan and a PCP doctor. This makes it easier for you to get the care you need. It is L.A. Care and Anthem Blue Cross’ job to make sure you get the care you need. For example, if you need to see a specialist, it is your PCP doctor’s and our job to find a specialist who will see you.

In “fee-for-service” Medi-Cal, you are not in a health plan and must find doctors and other providers who will accept payment from Medi-Cal. No one manages or coordinates your care for you. No one helps you find doctors and providers who will accept payment from Medi-Cal.

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

Mandatory Medi-Cal managed care members

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

A mandatory member may disenroll from Medi-Cal managed care only if the member:
• Has a complex medical condition (such as HIV/AIDS or cancer), and
• Has been in Medi-Cal managed care less than 90 days, and
• Is being treated by a doctor who does not work with any Medi-Cal managed care health plan.

Otherwise, the member must choose a health plan like L.A. Care. For help with fee-for-service benefits outside of managed care, call L.A. Care or Anthem Blue Cross.

Voluntary Medi-Cal managed care members

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

- The disabled or elderly receiving Supplemental Security Income (SSI)
- Those 65 years or older
- American Indians and their household, and others who are eligible to get services from an Indian Health Center or Native American Health Clinic
- Children in foster care or the Adoption Assistance Program
- Members with HIV/AIDS diagnosis

Voluntary disenrollment

To “disenroll” means you leave a health plan and are no longer a member. To disenroll from L.A. Care, call Health Care Options at 1-800-430-4263. Health Care Options enrolls or disenrolls Medi-Cal beneficiaries in or out of a Medi-Cal managed care health plan. They will send you a disenrollment form. Your membership will end on the last day of the month in which Health Care Options approves your request. Disenrollment takes 15 to 45 days. You must continue to receive services through Anthem Blue Cross until you are disenrolled from L.A. Care/Anthem Blue Cross.

If you leave L.A. Care, you can’t stay enrolled with Anthem Blue Cross for your Medi-Cal coverage.

Involuntary disenrollments

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

- You move out of Los Angeles County permanently.
- You are in a long-term care or intermediate care facility beyond the month of admission and the following month.
- You require medical health care services not provided by Anthem Blue Cross (for example, some major organ transplants and chronic kidney dialysis).
- You have other non-government or government-sponsored health coverage.
- You are in prison or jail.

If you are a mandatory or voluntary member you can also be disenrolled from L.A. Care/Anthem Blue Cross, even if you don’t want to leave, if:

- You take part in any fraud having to do with services, benefits or facilities of the plan.
- You show an ongoing significant disruptive behavior toward other members, providers, provider staff, or L.A. Care/Anthem Blue Cross.
- Anthem Blue Cross is not able, in good cause, to give health care services to you. Anthem Blue Cross will use their best efforts to provide the needed services.
If you are disenrolled from L.A. Care/Anthem Blue Cross, we will send you a letter that says when your coverage will end and why. You may file an appeal with the California Department of Managed Health Care (DMHC) if you think that your cancellation is because of your health status or need for services. This means you can ask DMHC to make sure we are allowed to disenroll you. You may also ask for a review from the California Department of Health Care Services (DHCS). You can learn more about this in the “Complaints: What should I do if I am unhappy?” section of this handbook. You can also call L.A. Care to find out more.

**Expedited disenrollment**

L.A. Care will process an Expedited Disenrollment if we are not able to provide you with medical services due to your condition or situation which is indicated in L.A. Care’s contract with the California Department of Health Care Services (DHCS). This may include a major organ transplant, long-term care service, Foster Care or Adoption Assistance Programs, or if you move out of Los Angeles County. We will submit a disenrollment request to DHCS, which will make a decision within 72 hours. When we receive the decision, we will notify you and your PCP doctor of the effective date of disenrollment. Your health care for the condition will be covered by regular Medi-Cal.

**Transitional Medi-Cal**

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

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

For example, if you are the person in your household who earns the most money, you might get transitional Medi-Cal. Even if you are a caretaker relative, you might get transitional Medi-Cal if you started earning more money or you are receiving more child or spousal support.

Parents and caretaker relatives who get transitional Medi-Cal can get free Medi-Cal coverage for six (6) to 24 months. If you stopped getting Medi-Cal, you should ask your eligibility worker if you qualify for transitional Medi-Cal. Call your eligibility worker at DPSS toll-free at 1-877-481-1044. You can stay with L.A. Care/Anthem Blue Cross if you are eligible for transitional Medi-Cal.
Getting involved: How do I participate?

Many L.A. Care/Anthem Blue Cross policies are decided by California Department of Health Services. Other policies are set by L.A. Care and/or Anthem Blue Cross and members like you.

Anthem Blue Cross Public Policy Committee

Anthem Blue Cross has a public policy committee you may join. This committee discusses member and health plan issues. To find out more, please call Anthem Blue Cross.

L.A. Care Regional Community Advisory Committees

There are 11 L.A. Care Regional Community Advisory Committees (RCAC) in Los Angeles County. (RCAC is pronounced “rack.”) Their purpose is to give input to L.A. Care that might affect policies, procedures, programs and practices.

RCAC members:

- Talk about member issues.
- Advise the L.A. Care Board of Governors.
- Educate and empower the community on health care issues.

RCACs meet once a month. RCACs include L.A. Care members, member advocates (supporters) and health care providers. To find out more about RCACs, call the L.A. Care Community Outreach and Education Department toll-free at 1-888-LACARE2 (1-888-522-2732).

Board of Governors meetings

The Board of Governors decides policies for L.A. Care. Anyone can attend these meetings. The Board of Governors meets on the first Thursday of each month from 2 p.m. to 4 p.m. To find out more call the L.A. Care Meeting Information Line at 1-213-438-5408.

Communicating policy changes

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

If you travel outside of Los Angeles County

As a member of L.A. Care and Anthem Blue Cross, your service area is Los Angeles County. All locations outside of Los Angeles County are out of your service area.

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

How a provider gets paid

Health care providers can be paid in several ways by the health plan or medical group which they may have a contract with. Providers may receive:

- A fee for each service provided
- Capitation (a flat rate paid each month per member)
- Provider incentives or bonuses

Please call Anthem Blue Cross if you would like to know more about how your doctor is paid or about financial incentives or bonuses.

If you have other insurance

Please call Anthem Blue Cross at 1-888-285-7801 to tell us about any health insurance you have other than L.A. Care/Anthem Blue Cross so we can send all bills to the correct place for payment.

Workers’ Compensation

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

Third party liability

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

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

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

Medi-Cal Estate Recovery Program

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

To learn more about the Medi-Cal Estate Recovery Program, write or call DHCS.
Disruption in services

L.A. Care will use its best efforts to provide services in the event of a war, riot or other unusual event. If L.A. Care/Anthem Blue Cross is not able to provide health services, we will send members to the nearest hospital for emergency services and pay for these services.

Organ donation

There is a need for organ donors in the United States. You can agree to donate your organs in the event of your death. The California Department of Motor Vehicles (DMV) will give you a donor card if you wish to become an organ or tissue donor. The DMV will also give you a donor sticker to place on your driver’s license or ID card. To find out more, call 1-800-777-0133 (voice) or 1-800-368-4327 (TTY).

What is an advance directive?

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

New technology

L.A. Care and Anthem Blue Cross follow changes and advances in health care. We study new treatments, medicines, procedures and devices. We call all of this “new technology.” We review scientific reports and information from the government and medical specialists. Then we decide whether to cover the new technology. Members and providers may ask L.A. Care or Anthem Blue Cross to review new technology.
Glossary of Terms

This glossary will help you understand words used in this Member Handbook.

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

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

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

**Arbitration** is the process by which parties to a dispute submit their differences to the judgment of an impartial (fair and unbiased) person or group appointed by mutual consent or statutory provision.

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

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

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

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

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

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

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

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

**Certified Nurse Practitioner** is a registered nurse who has completed an advanced training program in a medical specialty.

**Child Health and Disability Prevention (CHDP)** is for people under the age of 21 with a disability. CHDP is a preventive program that delivers periodic health assessment and services. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

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

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

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

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

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

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

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

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

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

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

**Emergency Services** are covered anywhere – 24 hours a day, seven (7) days a week. Emergency care is a service a member reasonably believes is necessary to stop or relieve serious illness or symptoms, injury, or conditions requiring immediate diagnosis and treatment, including physical and psychiatric emergency conditions and active labor.

**Evidence of Coverage and Disclosure Form (EOC)** is the L.A. Care Member Handbook which has information about benefits, services and terms for members.

**Exclusions** are any medical, surgical, hospital or other treatments for which the program offers no coverage.

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

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

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

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

**Federally Qualified Health Center (FQHC)** is a community-based health organization that provides comprehensive primary health, oral health, mental health, and substance abuse services.
**Food and Drug Administration (FDA)** is the U.S. government agency that enforces the laws on the manufacturing, testing, and use of drugs and medical devices.

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

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

**Health care services** prevent and treat disease, and keep people healthy. Examples include some of the following:

- Doctor services (includes one-on-one visits with a doctor and referrals)
- Emergency services (includes ambulance and out-of-area coverage)
- Home health services
- Hospital inpatient and outpatient services
- Laboratory services
- Pharmacy services
- Preventive health services
- Radiology services

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

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

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

**Hospital** provides inpatient and outpatient care from doctors or nurses.

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

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

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

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

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

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

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

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

**Local Education Agency** is the school district or county office of education that will receive and disburse grant funds.
Managed care is a health care system in which the health care provider, in return for a fixed fee per year from a health plan, manages the care of the individual, including decisions about whether a specialist is required.

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

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

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

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

Medically necessary/Medical necessity refers to all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to ease severe pain through the diagnosis or treatment of disease, illness or injury.

Member is a person who has joined a health plan.

Member Handbook, also called a Combined Evidence of Coverage/Disclosure Form, is what you are reading right now. It has information about the benefits, services and terms offered by the health plan.

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

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

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

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

Non-contracted provider is a doctor or provider who is not under contract with the health plan to provide services to members.

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

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

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

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

Outpatient is when a person receives medical treatment in a hospital or other health care facility without an overnight stay.
Out-of-area services are emergency care or urgent care services provided outside of the health plan’s service area that could not be delayed until the member returned to the service area.

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

Pharmacy is a place to get prescribed drugs.

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

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

Physician is a licensed medical doctor.

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

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

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

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

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

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

Providers are contracted with a health plan to provide covered health care services. Examples include:

- Doctors
- Clinics
- Hospitals
- Skilled nursing facilities
- Home health agencies
- Pharmacies
- Laboratories
- X-ray facilities
- Durable medical equipment suppliers

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

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

Referrals are when a doctor sends a member to another doctor, such as a specialist or providers of services including lab, X-ray, physical therapy and others.

Service area means the zip codes in Los Angeles County that the health plan, to which a member is assigned, serves.

Skilled nursing facility (SNF) is a facility licensed to provide medical services for non-acute conditions.
Specialist is a physician or other health professional who has advanced education and training in a clinical area of practice and is accredited, certified, or recognized by a board of physicians or peer group, or an organization offering qualifying examinations (board certified) as having special expertise in that clinical area of practice.

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

- Psychiatric inpatient hospital services
- Targeted case management
- Psychiatric services
- Psychologist services

• Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services

Speech therapy is used to treat speech problems.

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

TTY/TDD is a telecommunications device for the deaf.

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

Women, Infant and Children Program (WIC) is a state nutrition program that helps pregnant women, new mothers and young children eat well and stay healthy.
Important Phone Numbers

L.A. Care Health Plan 1-888-839-9909
L.A. Care Compliance Helpline 1-800-400-4889
Anthem Blue Cross 1-888-285-7801
Anthem Blue Cross Nurse Advice Line 1-888-285-7801

Disability Services
California Relay Service (CRS) – TTY/TDD 711
Sprint 1-888-877-5379 (Voice)
MCI 1-800-735-2922 (Voice)
Americans with Disabilities Act (ADA) Information Line 1-800-514-0301 (Voice)
1-800-514-0383 (TDD)

Children Services
California Children’s Services (CCS) 1-800-288-4584
Child Health and Disability Prevention (CHDP) 1-800-993-2437
(1-800-993-CHDP)

California State Services
California Department of Health Services (CDHS) 1-916-445-4171
CDHS Ombudsman Office 1-888-452-8609
Denti-Cal Beneficiary Services 1-800-322-6384
Department of Social Services 1-800-952-5253
Department of Managed Health Care (DMHC) 1-888-466-2219
(1-888-HMO-2219)

Health Care Options:
Armenian 1-800-840-5032
Cambodian/Khmer 1-800-430-5005
Cantonese 1-800-430-6006
English 1-800-430-4263
Farsi 1-800-840-5034
Hmong 1-800-430-2022
Lao 1-800-430-4091
Russian 1-800-430-7007
Spanish 1-800-430-3003
Tagalog 1-800-576-6890
Vietnamese 1-800-430-8008

U.S Office for Civil Rights 1-866-627-7748
1-866-788-4989 (TTY)
Social Security Administration

Supplemental Social Income (SSI) 1-800-772-1213

Los Angeles County Services

Department of Public Social Services (DPSS)
Central Help Line (includes language services) 1-877-481-1044
Customer Service Center 1-866-613-3777

DPSS Public Charge Information Lines

Los Angeles County Department of Health Services 1-213-250-8055
Los Angeles County Department of Mental Health 1-800-854-7771
Women, Infant and Children (WIC) Program 1-888-942-9675
Other Things to Know About Your Health Plan

- **Child Health and Disability Prevention Program (CHDP)** – Checkups to keep your family healthy.

- **What to Do if You Are Pregnant** – Steps you need to take if you are pregnant right now.

- **24/7 NurseLine** – A 24-hour nurse help line that also has taped messages on more than 300 health topics.

- **Preventive Health Care Guidelines** – To help you and your family see your primary care physician (PCP) at the right times.

- **Notice of Privacy Practices** – A guide to what we do with your health information.

- **PCP Selection form** – To change your PCP, just call us or complete and mail this form.
Good health is one of the most important things you can give your children. You can help keep them healthy if:

- You take them to their primary care physician (PCP) for regular checkups.
- You take them to their PCP for vaccines (shots).
- You take them to their eye doctor and dentist on a regular basis.

As part of their benefits, your children receive CHDP services. These include free checkups for children under 21 years of age. These free checkups are known as “Well-Child visits.”

During a Well-Child visit, your child’s PCP may check your child’s:

- Body
- Ears
- Vision
- Teeth
- Growth

Well-Child benefits also include:

- Health education services to teach you how to manage any medical conditions found during a Well-Child visit.
- Routine shots.
- Lab tests.

Ask your child’s PCP when your child should return for the next Well-Child visit.

If you need help with setting up a Well-Child visit, call us at **1-800-407-4627** (Medi-Cal) or **1-888-285-7801** (L.A. Care). If you have hearing or speech loss, call the TTY line at **1-888-757-6034**. If you need help getting to and from your PCP’s office, call us.
If you are pregnant, call us right away!

We offer a program called Healthy Habits Count for You and Your Baby at no cost to you. It can help you and your baby get the right care while you’re pregnant. You can get a reward when you complete your postpartum visit within 21 to 56 days after your baby is born.

Si está embarazada, llamámenos de inmediato!

Le ofrecemos un programa llamado Los hábitos saludables son importantes para usted y su bebé (Healthy Habits Count for You and Your Baby) sin costo. Puede ayudarla a usted y a su bebé a obtener la atención adecuada durante su embarazo. Puede obtener un premio cuando realice su visita postparto dentro de los 21 a 56 días después de que nazca su bebé.

إذا كنت حاملاً اتصلنا فوراً! Arabic

Հաճախե՞ք ծառը, իրարերարերեր ծավալեքերի փոխ: Armenian

如果您懷孕了，請立刻打電話給我們！ Chinese

اگر حامله هستید، فوراً با ما تماس بگیرید! Farsi

Yog koj cev xeeb tub lawm, cia li hu rau peb sai sai! Hmong

លោក្លាមខ្លួនឯងក្លាម្នាក់របស់អ្នកខ្លួន! Khmer

임신부께서는 즉시 연락주십시오! Korean

Если вы беременны, немедленно позвоните нам! Russian

Kung kayo ay buntis, tawagan nyo kami kaagad! Tagalog

Nếu quý vị đang mang thai, xin gọi ngay cho chúng tôi! Vietnamese
Do you want to reach a nurse right away? Do you need information about a health condition?

Call 24 Hours a Day
1-800-224-0336
TTY 1-800-368-4424

We know being healthy is important to you and your family. By calling our 24/7 NurseLine, you can reach a nurse or learn about health issues 24 hours a day, seven days a week. Our 24/7 NurseLine also has nurses trained to give teens information about their specific health issues. The calls are private. Phone interpreters are available for non-English speakers.

You can reach a registered nurse to:

• Help answer questions about your health, common health problems and prescription drugs.
• Help you prepare for your first visit to a new doctor.
• Help you find local health care services.

How to Use our 24/7 NurseLine:

Call the toll-free number 1-800-224-0336 or the TTY at 1-800-368-4424 if you have hearing or speech loss. Follow the directions. If you choose to ask for a nurse, you will be transferred to one of the nurses right away. Try it. It’s easy.

24/7 NurseLine is not for emergencies.

If someone needs emergency health care, call 911 right away. Don’t wait! Our 24/7 NurseLine gives general information only, not medical advice. Please ask your doctor for medical advice.

Access audio topics on many subjects such as:

• Infant and child health
• Men’s health
• Asthma
• Pregnancy
• Women’s health
• Cancer
• Diabetes
• First aid and emergencies

The health topics are in English and Spanish.

When you call our 24/7 NurseLine, you can get free, private health information by phone.

1. Call toll-free at 1-800-224-0336. Members with hearing or speech loss may call the TTY line at 1-800-368-4424.

2. Follow the voice prompts to reach the audio health library (press 3).

3. Enter your topic number when prompted.

Our members can use this free service as often as they want. The topics and their numbers are listed on the following pages.
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<td>Insect and Spider Bites and Stings</td>
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<tr>
<td>Snake Bites</td>
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<td>Tick Bites</td>
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<tr>
<td>Heat Exhaustion and Heat Stroke</td>
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<tr>
<td>Burns</td>
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<td>Cuts</td>
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<tr>
<td>Poisoning</td>
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<tr>
<td>Puncture Wounds</td>
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<tr>
<td>Removing Splinters</td>
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<tr>
<td>Heart Attack and Unstable Angina</td>
</tr>
<tr>
<td>Importance of CPR Instructions</td>
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<tr>
<td>Hypothermia</td>
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<td>Frostbite</td>
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<tr>
<td><strong>Partnership With Your Doctor</strong></td>
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<tr>
<td>Patient’s Bill of Rights</td>
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<td>Caregiver Secrets</td>
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<td>Skills for Making Wise Health Decisions</td>
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<td>Work in Partnership with Your Doctor</td>
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<td>Finding a Doctor Who Will be a Partner</td>
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<td>Health Screenings</td>
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<td>Guidelines for Eating Well</td>
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<td>Fitness</td>
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<tr>
<td>Alcohol and Drug Problems</td>
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<tr>
<td>Be Tobacco-Free</td>
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<td>Stress Management: What Is Stress?</td>
</tr>
<tr>
<td><strong>Home Health Medicines and Supplies</strong></td>
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<tr>
<td>How to Take a Temperature</td>
</tr>
<tr>
<td>Self-Care Supplies</td>
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<td>Bulking Agents and Laxatives</td>
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<td>Pain Relievers</td>
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<tr>
<td>Decongestants</td>
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<tr>
<td>Cough Preparations</td>
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<tr>
<td>Cold and Allergy Remedies</td>
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<tr>
<td><strong>Abdominal Problems</strong></td>
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<tr>
<td>Colon Polyps</td>
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<tr>
<td>Dehydration</td>
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<tr>
<td>Urinary Tract Infections in Teens and Adults</td>
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<td>Food Poisoning</td>
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<td>Inguinal Hernia</td>
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<td>Nausea and Vomiting – Age 4 and Older</td>
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<td>Appendicitis</td>
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<td>Ulcerative Colitis</td>
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<td>Diverticulosis</td>
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<td>Rectal Problems</td>
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<td>Heartburn</td>
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<tr>
<td>Irritable Bowel Syndrome</td>
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<td>Gastroesophageal Reflux Disease</td>
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<tr>
<td>Peptic Ulcer Disease</td>
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<td>Crohn’s Disease</td>
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<td>Hepatitis</td>
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<tr>
<td>Hepatitis B</td>
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<td>Gallbladder Surgery</td>
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<td>Urinary Incontinence in Women</td>
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<td>Kidney Stones</td>
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<td><strong>Back and Neck Pain</strong></td>
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<tr>
<td>Low Back Pain</td>
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<tr>
<td>Neck Pain</td>
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<tr>
<td>Herniated Disk</td>
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<tr>
<td>Surgery for Low Back Problems</td>
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<tr>
<td><strong>Bone, Muscle and Joint Problems</strong></td>
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<td>Arthritis</td>
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<tr>
<td>Juvenile Rheumatoid Arthritis</td>
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<tr>
<td>Osteoporosis</td>
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<tr>
<td>Lupus</td>
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<tr>
<td>Rheumatoid Arthritis</td>
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<tr>
<td>Fibromyalgia</td>
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<tr>
<td>Gout</td>
</tr>
<tr>
<td>Sports Injuries</td>
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<tr>
<td>Temporomandibular (TM) Disorders</td>
</tr>
<tr>
<td>Bunions</td>
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<tr>
<td>Calluses and Corns</td>
</tr>
<tr>
<td>Plantar Fasciitis</td>
</tr>
<tr>
<td>Bursitis and Tendon Injury</td>
</tr>
<tr>
<td>Carpal Tunnel Syndrome</td>
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<tr>
<td>Strains, Sprains, Fractures and Dislocations</td>
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<tr>
<td>Muscle Cramps and Leg Pain</td>
</tr>
<tr>
<td>Surgery for Carpal Tunnel Syndrome</td>
</tr>
<tr>
<td>Rotator Cuff Disorders</td>
</tr>
<tr>
<td>Osteoarthritis</td>
</tr>
<tr>
<td><strong>Chest, Respiratory and Circulatory Problems</strong></td>
</tr>
<tr>
<td>Stroke Rehabilitation</td>
</tr>
<tr>
<td>Colds</td>
</tr>
<tr>
<td>Influenza (Flu)</td>
</tr>
<tr>
<td>Sinusitis</td>
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<tr>
<td>Viral and Bacterial Infection</td>
</tr>
<tr>
<td>Fever</td>
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<tr>
<td>Strep Throat</td>
</tr>
<tr>
<td>Swollen Lymph Nodes</td>
</tr>
<tr>
<td>Laryngitis</td>
</tr>
<tr>
<td>Chest Pain</td>
</tr>
<tr>
<td>Causes of Heart Attack</td>
</tr>
<tr>
<td>Heart Attack Prevention</td>
</tr>
</tbody>
</table>
Heart Failure
Atrial Fibrillation (Irregular Heartbeats)
Mitral Valve Prolapse
Pacemakers
Varicose Veins
Cardiac Rehabilitation
Chronic Obstructive Pulmonary Disease (COPD)
Emphysema
Asthma in Teens and Adults
Acute Bronchitis
Pneumonia
Bell’s Palsy
Encephalitis
Guillain-Barre Syndrome
Tension Headaches
Migraine Headaches
Diabetic Neuropathy
Ear Infections
Dizziness and Vertigo
Diabetic Retinopathy
Tonsillitis
Earwax
Labyrinthitis (Inner Ear Infection)
Swimmer’s Ear
Meniere’s Disease
Hearing Loss
Eye Problems
Contact Lens Care
Eye Injuries
Styes and Chalazia
Eye Inflammations
Cataracts
Color Blindness
Age-Related Macular Degeneration
Glaucma
Strabismus
Laser Surgery for Nearsightedness – Radial Keratotomy
Floaters and Flashes
Cataract Surgery
Skin Problems
Skin Cancer
Lice and Scabies
Blisters
Ingrown Toenails
Acne
Boils
Cold Sores
Dandruff
Atopic Dermatitis
Hives
Rashes
Psoriasis
Fungal Infections
Shingles
Sunburn
Warts
Dyslexia
Temper Tantrums
Attention Deficit Hyperactivity Disorder (ADHD)
Bed-Wetting
Fever – Age 3 and Younger
Chickenpox
Circumcision
Colic
Croup
Reye’s Syndrome
Diaper Rash
Fifth Disease
Growth and Development of the Newborn
Hand-Foot-and-Mouth Disease
Impetigo
Measles
Mumps
Childhood Rashes
Pinworms
Roseola
Rubella (German Measles)
Sudden Infant Death Syndrome (SIDS)
Teething
Thumb-Sucking
Toilet Training
Thrush
Urinary Tract Infections in Children
Healthy Eating for Children
Alcohol’s Effects on a Fetus
Bottle-feeding
Breast Health
Polycystic Ovary Syndrome
Multiple Pregnancy: Twins or More
Gestational Diabetes
Breast Biopsy
Ultrasound for Normal Pregnancy
Fertility Problems
Sexual Dysfunction in Women
Pelvic Ligation and Tubal Implants
Pelvic Inflammatory Disease
Precautions during Pregnancy
Bacterial Vaginosis
Vaginal Yeast Infections
Menopause and Perimenopause
Hormone Therapy
Missed or Irregular Periods
Endometriosis
Uterine Fibroids
Hysterectomy
Bleeding Between Periods
Functional Ovarian Cysts
Laparoscopy

Ear Tubes

Tonsillectomy and Adenoidectomy

Shared Decisions about Surgery

**Sleeping Disorders**

- Insomnia
- Sleep Apnea
- Snoring

**Mental Health Problems and Mind-Body Wellness**

- Bipolar Disorder – Manic Depression
- Schizophrenia
- Dementia
- Domestic Violence
- Child Maltreatment
- Stress Management: What Happens When You’re Stressed?
- Obsessive-Compulsive Disorder
- Eating Disorders
- Panic Attacks and Panic Disorders
- Depression
- Grief
- Social Anxiety Disorder
- Suicide
Preventive Health Care Guidelines

Anthem Blue Cross wants to help you and your family stay healthy. Routine visits to the doctor are important.

These guidelines tell you about exams, screenings and vaccines that are helpful for infants, children, young adults and adults.
Guidelines for Healthy Children and Young Adults*

Children should visit their doctor on a routine basis for Well-Child exams. The chart below shows what ages these exams and other tests should take place. Your children may need other exams or tests due to their medical history. Talk to your doctor. During office visits, ask your doctor how to prevent injuries and violence. You should also ask how to manage behavior, eat right and what to expect as your child grows.

<table>
<thead>
<tr>
<th>Well Visit Checkups and Tests</th>
<th>INFANCY</th>
<th>CHILDHOOD</th>
<th>ADOLESCENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Child Visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every visit should include medical history, physical exam, height, weight, growth, head circumference (infancy only), blood pressure (3 years of age and older) body mass index (24 months of age and older), vision and hearing tests, developmental and behavioral tests, a visual dental exam, and age-specific health education and behavioral assessment as necessary.</td>
<td>Newborn: 3 to 5 days; 1, 2, 4, 6, 9, 12, 15, 18, and 24 months of age</td>
<td>Every year from 2 to 10 years of age</td>
<td>Every year from 11 to 21 years of age</td>
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<tr>
<td>Urine Test</td>
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<tr>
<td></td>
<td>At 5 years of age and every 2 to 3 years</td>
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<tr>
<td>Dental Exam by a Dentist</td>
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<td></td>
<td>At 12 months of age, or earlier if appropriate; follow-up as prescribed by dentist</td>
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<tr>
<td>Cholesterol Screening</td>
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<tr>
<td>(high-risk patients)</td>
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<td></td>
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<tr>
<td></td>
<td>When doctor recommends, beginning at 24 months of age</td>
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<tr>
<td>Pelvic Exam and Cervical</td>
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<tr>
<td>Cancer Screening</td>
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<tr>
<td></td>
<td>Every year for sexually active females (no matter what age), or starting at 18 years of age</td>
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<tr>
<td>Sexually Transmitted</td>
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<tr>
<td>Disease Screening</td>
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<tr>
<td></td>
<td>Every year for sexually active patients</td>
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<tr>
<td>Blood Test (anemia)</td>
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<tr>
<td></td>
<td>Once between 9 and 12 months of age For high-risk patients, once between 15 months and 5 years of age</td>
<td>Once between 11 and 21 years of age Every year for menstruating patients; and when doctor recommends</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis (TB) Test</td>
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<tr>
<td>(high-risk patients)</td>
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<td></td>
<td>When doctor recommends.</td>
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<tr>
<td>Sickle Cell Test and</td>
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<tr>
<td>Hereditary/Metabolic</td>
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<tr>
<td>Screening (thyroid, PKU,</td>
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<tr>
<td>galactosemia, hemoglobinopathies)</td>
<td>State law requires by 1 month of age</td>
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<tr>
<td>Lead Test (^2)</td>
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<tr>
<td></td>
<td>Once between 9 and 12 months of age and again at 24 months of age</td>
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</tbody>
</table>

* The guidelines above are taken from the Recommendations for Preventive Pediatric Health Care; Bright Futures (2008); and the American Academy of Pediatrics (AAP). For more information visit http://pediatrics.aappublications.org/cgi/content/full/pediatrics;120/6/1376/DC1.

1 This is also recommended by the AAP. State laws require testing of newborn babies for certain medical conditions before they leave the hospital or birthing center.

2 The Centers for Medicare and Medicaid Services (CMS) requires a blood lead test at 12 and 24 months. For more information visit http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn.
Vaccines for Healthy Children and Young Adults*

All children should get needed vaccines (preventive shots) when they see the doctor for health care or Well-Child visits. These shots protect children from disease. The chart below has the shots your child should have for 2008 as they grow. Vaccines are given based on the most recent schedule published by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics.

<table>
<thead>
<tr>
<th>VACCINES</th>
<th>Birth</th>
<th>1-2 mos</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>6-18 mos</th>
<th>12-15 mos</th>
<th>12-18 mos</th>
<th>12-23 mos</th>
<th>15-18 mos</th>
<th>4-6 yrs</th>
<th>11-12 yrs</th>
<th>13-19 yrs</th>
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</thead>
<tbody>
<tr>
<td>Hepatitis A Series (HepA)</td>
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<td>Hepatitis B (HepB)</td>
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<tr>
<td>Diphtheria, Tetanus, Pertussis</td>
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<td>Haemophilus Influenzae Type b (Hib)</td>
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<td>Inactivated Poliovirus (IPV)</td>
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<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
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<tr>
<td>Varicella (Chickenpox)</td>
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<td>Meningococcal Conjugate (MCV4)</td>
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<tr>
<td>Human Papillomavirus (HPV)</td>
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<td>Females only – minimum age 9 years</td>
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<td>Rotavirus</td>
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<td>Influenza (Flu)</td>
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</table>

Catch-up shots may be given during these years. Talk to your doctor.

If your child misses ANY of these shots or tests, talk to your doctor about a catch-up plan.

* The information in the chart is taken from the most recent Centers for Disease Control and Prevention Recommended Immunization Schedules for persons aged 0 to 18 years (United States, 2008). The immunization schedules are approved by the American Academy of Family Physicians. The schedules are available at http://www.cdc.gov/MMWR/preview/mmwrhtml/mm5701a8.htm.
### Guidelines for Pregnant Women

The chart below shows which vaccines, tests, exams, advice and education may happen at each well visit before, during and after pregnancy. These guidelines come from the Institute for Clinical Systems Improvement (ICSI)\(^1\) and the American College of Obstetricians and Gynecologists (ACOG).\(^2\) They are for low-risk pregnancies. Talk to your doctor if you have concerns about your pregnancy. Your doctor will decide what tests and exams you need.

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**Before Pregnancy**

<table>
<thead>
<tr>
<th>Screening and Tests</th>
<th>Counseling and Education</th>
<th>Lab Tests and Shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical History</td>
<td>Preterm Labor Education and Prevention</td>
<td>Rubella Shot (at least 3 months prior to becoming pregnant)</td>
</tr>
<tr>
<td>Complete Physical</td>
<td>Smoking, Drug, and Alcohol Use</td>
<td>Measles, Mumps, Rubella (MMR)</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Nutrition and Weight</td>
<td>Tetanus Booster</td>
</tr>
<tr>
<td>Height and Weight</td>
<td>Domestic Abuse</td>
<td>Hepatitis B Vaccine</td>
</tr>
<tr>
<td>BMI</td>
<td>List of Medications, Herbal Supplements, and Vitamins</td>
<td>Varicella Vaccine (at least 3 months prior to becoming pregnant, if needed)</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>Health Hazards at Work and in the Community</td>
<td>Screening for Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>Risk Factors</td>
<td>Accurate Recording of Menstrual Dates</td>
<td>Screening for HIV (with consent)</td>
</tr>
<tr>
<td>Cholesterol and HDL</td>
<td>Folic Acid – 400 Micrograms Daily (start taking at least one month before getting pregnant)</td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td></td>
<td>Flu Shot</td>
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<tr>
<td>Rubella and Rubeola</td>
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</tr>
</tbody>
</table>

**Visit 1 (6 to 8 Weeks)**

<table>
<thead>
<tr>
<th>Screening and Tests</th>
<th>Counseling and Education</th>
<th>Lab Tests and Shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical History</td>
<td>Smoking, Drug and Alcohol Use</td>
<td>Pregnancy Test</td>
</tr>
<tr>
<td>Complete Physical</td>
<td>Physical Activity</td>
<td>Cervical Cancer Test</td>
</tr>
<tr>
<td>Height and Weight</td>
<td>Sauna and Hot Tub Exposure</td>
<td>Complete Blood Count Hemoglobin</td>
</tr>
<tr>
<td>BMI</td>
<td>Nutrition, Vitamins, and Folic Acid</td>
<td>Blood Type and D Type</td>
</tr>
<tr>
<td>Estimated Date of Delivery</td>
<td>Toxoplasmosis</td>
<td>Antibody Screen</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>Warning Signs</td>
<td>Urine Culture/Screen</td>
</tr>
<tr>
<td></td>
<td>Signs of Labor</td>
<td>HIV Screening (with consent)</td>
</tr>
<tr>
<td></td>
<td>Type of Birth</td>
<td>Blood Lead Screening</td>
</tr>
<tr>
<td></td>
<td>Course of Care</td>
<td>Hepatitis</td>
</tr>
<tr>
<td></td>
<td>Childbirth Classes</td>
<td>Tetanus Booster</td>
</tr>
<tr>
<td></td>
<td>Fetal Activity</td>
<td>ABO/RH/Ab</td>
</tr>
<tr>
<td></td>
<td>Changes in Pregnancy</td>
<td>Rubella Test</td>
</tr>
<tr>
<td></td>
<td>Environment or Work Hazards</td>
<td>Syphilis</td>
</tr>
<tr>
<td></td>
<td>Lab Tests for Fetal Problems</td>
<td>Flu Shot</td>
</tr>
<tr>
<td></td>
<td>Early Labor</td>
<td>Varicella Test (if needed)</td>
</tr>
<tr>
<td></td>
<td>Risk Assessment including Medical, Obstetrical, Nutritional, Psychological, and Health Education Needs (to be followed up once each trimester and at postpartum visit)</td>
<td>[If Doctor Recommends:]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screening for Genetic Disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screening for Sexually Transmitted Diseases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood Disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tuberculosis</td>
</tr>
</tbody>
</table>

**Visit 2 (10 to 12 Weeks)**

<table>
<thead>
<tr>
<th>Screening and Tests</th>
<th>Counseling and Education</th>
<th>Lab Tests and Shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for Fetal Problems</td>
<td>Fetal Growth</td>
<td>If Doctor Recommends:</td>
</tr>
<tr>
<td>Urine Test</td>
<td>Review Labs from Visit 1</td>
<td>Amnio/Chorionic Villus Sampling (8 to 18 weeks)</td>
</tr>
<tr>
<td></td>
<td>Breastfeeding</td>
<td>Karyotype</td>
</tr>
</tbody>
</table>

---

1. [http://www.icsi.org](http://www.icsi.org)
2. [http://www.acog.org](http://www.acog.org)
## Visit 3 (15 to 18 Weeks)

<table>
<thead>
<tr>
<th>Screening and Tests</th>
<th>Counseling and Education</th>
<th>Lab Tests and Shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervix Exam</td>
<td>Second Trimester Growth</td>
<td>Flu Shot (if needed)</td>
</tr>
<tr>
<td>Urine Test</td>
<td>Quickening (first fetal movements)</td>
<td>If Doctor Recommends:</td>
</tr>
<tr>
<td>Screening for Fetal Problems</td>
<td>Umbilical Cord Blood Banking</td>
<td>Maternal Serum Alpha Fetoprotein/Multiple Markers</td>
</tr>
<tr>
<td>Ultrasound (if doctor recommends)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Visit 4 (22 Weeks)

<table>
<thead>
<tr>
<th>Screening and Tests</th>
<th>Counseling and Education</th>
<th>Lab Tests and Shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervix Exam</td>
<td>Length of Stay in Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RH Factor</td>
<td>Gestational Diabetes Mellitus (GDM)</td>
</tr>
<tr>
<td></td>
<td>Work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preregistration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fetal Movement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Newborn Sleeping Position</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Choosing the Baby’s Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Newborn Car Seat</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tubal Sterilization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Circumcision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breast or Bottle Feeding</td>
<td></td>
</tr>
</tbody>
</table>

## Visit 5 (24 to 28 Weeks)

<table>
<thead>
<tr>
<th>Screening and Tests</th>
<th>Counseling and Education</th>
<th>Lab Tests and Shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm Labor Risk</td>
<td>Work</td>
<td>Gestational Diabetes Mellitus (GDM)</td>
</tr>
<tr>
<td>Cervix Exam</td>
<td>Preregistration</td>
<td>Diabetes Screen</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>Anesthesia</td>
<td>Glucose Tolerance Test (if diabetes screen is abnormal)</td>
</tr>
<tr>
<td></td>
<td>Fetal Movement</td>
<td>ABO/RH Antibody Status and Shots (if needed)</td>
</tr>
<tr>
<td></td>
<td>Newborn Sleeping Position</td>
<td>Hepatitis</td>
</tr>
<tr>
<td></td>
<td>Choosing the Baby’s Doctor</td>
<td>Screening for Sexually Transmitted Diseases</td>
</tr>
<tr>
<td></td>
<td>Newborn Car Seat</td>
<td>If Doctor Recommends:</td>
</tr>
<tr>
<td></td>
<td>Tubal Sterilization</td>
<td>Complete Blood Count Hemoglobin</td>
</tr>
<tr>
<td></td>
<td>Circumcision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breast or Bottle Feeding</td>
<td></td>
</tr>
</tbody>
</table>

## Visit 6 (32 Weeks)

<table>
<thead>
<tr>
<th>Screening and Tests</th>
<th>Counseling and Education</th>
<th>Lab Tests and Shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound (if doctor recommends)</td>
<td>What You Can and Can’t Do When Pregnant</td>
<td>Culture for Group B Streptococcus</td>
</tr>
<tr>
<td></td>
<td>Choosing the Baby’s Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Labor and Delivery Issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Warning Signs of Complications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preparation for Discharge from Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual Activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Travel</td>
<td></td>
</tr>
</tbody>
</table>

## Visit 7 (36 Weeks)

<table>
<thead>
<tr>
<th>Screening and Tests</th>
<th>Counseling and Education</th>
<th>Lab Tests and Shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervix Exam</td>
<td>Labor Precautions</td>
<td>Culture for Group B Streptococcus</td>
</tr>
<tr>
<td>Check Fetal Position</td>
<td>Management of Late Pregnancy Symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Birth Control</td>
<td></td>
</tr>
<tr>
<td></td>
<td>When to Call the Doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Postpartum Depression (depression after baby is born)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care After Baby is Born</td>
<td></td>
</tr>
</tbody>
</table>

## Visits 8 through 11 (37 Weeks to Delivery)

<table>
<thead>
<tr>
<th>Screening and Tests</th>
<th>Counseling and Education</th>
<th>Lab Tests and Shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervix Exam</td>
<td>Labor and Delivery Update</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vaccines After Birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infant CPR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delay in Delivery Issues</td>
<td></td>
</tr>
</tbody>
</table>

## After the Birth

<table>
<thead>
<tr>
<th>Screening and Tests</th>
<th>Counseling and Education</th>
<th>Lab Tests and Shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit for Mother 3 to 6 weeks after Delivery</td>
<td>Breastfeeding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Birth Control Counseling and Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 to 6 Weeks after Delivery</td>
<td></td>
</tr>
</tbody>
</table>

We have a **Healthy Habits Count for You and Your Baby** prenatal program for all of our pregnant members. To find out more, call us at one of the phone numbers listed on the last page of these Guidelines. This program offers a free prenatal book with details on pregnancy and child care. Call and get your copy today.
## Guidelines for Healthy Adults

Adults should have routine visits with their doctor. Men and women need to have special tests at certain times in their lives. The chart below shows which exams should be done at which age. This chart was taken from the Agency for Healthcare Research and Quality Guide to Clinical Preventive Services (September 2007)¹, and from the most recent Centers for Disease Control and Prevention Recommended Adult Immunization Schedule (United States, October 2007 to September 2008)². This guide is used to decide which preventive services are needed for healthy adults 21 and older. Take this chart with you to your doctor. Ask if you are up-to-date or if you need any other exams, tests, shots or advice.

### IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Years of Age</th>
<th>19</th>
<th>25</th>
<th>30</th>
<th>35</th>
<th>40</th>
<th>45</th>
<th>50</th>
<th>55</th>
<th>60</th>
<th>65</th>
<th>70</th>
<th>75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus-Diphtheria (Td)</td>
<td>One dose every 10 years (all ages)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>Those who have not had chickenpox or have not had the shot before: Two doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>One or two doses (ask your doctor)</td>
<td>Anyone at high risk: One dose</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Pneumococcal</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Influenza (Flu)</td>
<td>Anyone at high risk: One dose yearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>One dose yearly (age 50 and older)</td>
</tr>
<tr>
<td>Herpes Zoster</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>One dose (age 60 and older)</td>
</tr>
</tbody>
</table>

### COUNSELING

<table>
<thead>
<tr>
<th>Years of Age</th>
<th>19</th>
<th>25</th>
<th>30</th>
<th>35</th>
<th>40</th>
<th>45</th>
<th>50</th>
<th>55</th>
<th>60</th>
<th>65</th>
<th>70</th>
<th>75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium Intake</td>
<td>Women of childbearing age</td>
<td>When doctor recommends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Folic Acid</td>
<td>Women of childbearing age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin (to prevent heart disease)</td>
<td>When doctor recommends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco Cessation, Drug and Alcohol Use, Sexually Transmitted Diseases and HIV, Nutrition, Physical Activity, Sun Exposure, Oral Health, Injury Prevention, and Polypharmacy</td>
<td>When doctor recommends</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
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</tr>
</tbody>
</table>

¹ Agency for Healthcare Research and Quality Guide to Clinical Preventive Services (September 2007)
² Centers for Disease Control and Prevention Recommended Adult Immunization Schedule (United States, October 2007 to September 2008)
### Guidelines for Healthy Adults (continued)

#### Range of Recommended Ages

<table>
<thead>
<tr>
<th>Years of Age</th>
<th>19</th>
<th>25</th>
<th>30</th>
<th>35</th>
<th>40</th>
<th>45</th>
<th>50</th>
<th>55</th>
<th>60</th>
<th>65</th>
<th>70</th>
<th>75</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SCREENINGS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>Every 1 to 3 years</td>
<td>Every 2 years</td>
<td>Yearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Every 2 years if 130/85 or lower – more often if higher (all ages)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Serum Cholesterol and HDL</td>
<td>If high-risk, begin at age 20</td>
<td>Men: At initial visit, then every 5 years</td>
<td>Women: At initial visit, then every 5 years</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic Exam, Pap Smear, and Cervical Cancer Screening</td>
<td>Women: Every year until 3 tests are normal, then every 1 to 3 years (age 18 through 65)</td>
<td>65 years and older – women with a new sexual partner</td>
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<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Yearly: Sexually active persons up to age 25</td>
<td>Afterwards, if doctor recommends</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td>Earlier if at high risk</td>
<td>Women: Every 1 to 2 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Breast Exam</td>
<td>Earlier if at high risk</td>
<td>Women: Yearly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>Depending on risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Screening for women 60 and older at higher risk for osteoporotic fractures</td>
<td>Women – routine screening</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis (TB)</td>
<td>When doctor recommends; Mantoux skin test for all persons at high risk</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>All adults (all ages)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

These guidelines may have changed since they were printed. This guide is not meant to take the place of medical care or advice. Always ask your doctor about the right test, treatment or care for you.

For questions about these guidelines, please call:

Anthem Blue Cross Partnership Plan (Medi-Cal) 1-800-407-4627
Healthy Families Program 1-800-845-3604
L.A. Care Health Plan 1-888-285-7801

TTY Line for all programs 1-888-757-6034
(TTY lines are for members with hearing or speech loss only.)
Notice of Privacy Practices

Effective: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Anthem Blue Cross provides health care to you for the Medi-Cal program. We are required by state and federal law to protect your health information. And we must give you this Notice that tells how we may use and share your information and what your rights are.

Your information is personal and private.

We receive information about you from Medi-Cal after you become eligible and enroll in our health plan. We also receive medical information from your doctors, clinics, labs, and hospitals in order to approve and pay for your health care.

CHANGES TO NOTICE OF PRIVACY PRACTICES

Anthem Blue Cross must obey the Notice currently in effect. We have the right to change these privacy practices. If we do make changes after April 14, 2003, we will revise this Notice and send it to you right away.
HOW WE MAY USE AND SHARE INFORMATION ABOUT YOU

Your information may be used or shared by Anthem Blue Cross only for a reason directly connected to the Medi-Cal Program. The information we use and share includes, but is not limited to:

- Your name.
- Address.
- Personal facts.
- Medical care given to you.
- Your medical history.

Some actions we take when we act as a Medi-Cal Health Plan include:

- Checking your eligibility, enrollment, and amount of medical aid.
- Approving, giving, and paying for Medi-Cal services.
- Investigating or prosecuting Medi-Cal cases (like fraud).
- Checking the quality of care that you receive.
- Coordinating the care you receive.

Some Examples:

1. **For treatment:** You may need medical treatment that requires us to approve care in advance. We will share information with doctors, hospitals and others in order to get you the care you need.

2. **For payment:** Anthem Blue Cross reviews, approves, and pays for health care claims sent to us for your medical care. When we do this, we share information with the doctors, clinics, and others who bill us for your care. And we may forward bills to other health plans or organizations for payment.

3. **For health care operations:** We may use information in your health record to judge the quality of the health care you receive. We may also use this information in audits, fraud and abuse programs, planning, and general administration.
OTHER USES FOR YOUR HEALTH INFORMATION

1. Sometimes a court will order us to give out your health information. We will also give information to a court, investigator, or lawyer if it is about the operation of Medi-Cal. This may involve fraud or actions to recover money from others, when Medi-Cal has paid your medical claims.

2. You or your doctor, hospital, and other health care providers may appeal decisions made about claims for your Medi-Cal care. Your health information may be used to make these appeal decisions.

3. We may also share your health information with agencies and organizations, which check how our health plan is providing services.

4. We must share your health information with the federal government when it is checking on how we are meeting privacy rules.

WHEN WRITTEN PERMISSION IS NEEDED

If we want to use your information for any purpose not listed above, we must get your written permission. If you give us your permission, you may take it back in writing at any time. We won’t use your information in the future. We won’t be able to take back the information we used when we had your permission.

WHAT ARE YOUR PRIVACY RIGHTS?

• You have the right to ask us not to use or share your personal health care information in the ways described above. We may not be able to agree to your request.

• You have the right to ask us to contact you only in writing or at a different address, post office box, or by telephone. We will accept reasonable requests when necessary to protect your safety.
• You and your personal representative have the right to get a copy of your health information. You will be sent a form to fill out and may be charged a fee for the costs of copying and mailing records. (We may keep you from seeing certain parts of your records for reasons allowed by law.)

• You have the right to ask that information in your records be amended if it is not correct or complete. We may not be able to do what you request if
  o The information is not created or kept by Anthem Blue Cross, or
  o We believe it is correct and complete.

• If we don’t make the changes you ask, you may ask that we review our decision. You may also send a statement saying why you disagree with our records and your statement will be kept with your records.

***** IMPORTANT *****

ANTHEM BLUE CROSS DOES NOT HAVE COMPLETE COPIES OF YOUR MEDICAL RECORDS. IF YOU WANT TO LOOK AT, GET A COPY OF, OR CHANGE YOUR MEDICAL RECORDS, PLEASE CONTACT YOUR DOCTOR OR CLINIC.

• When we share your health information after April 14, 2003, you have the right to request a list of:
  o Whom we shared the information with.
  o When we shared it.
  o For what reasons.
  o What information was shared.

This list will not include when we share information with you, with your permission, or for treatment, payment, or health plan operations.

You have a right to request a paper copy of this Notice of Privacy Practices. You can also find this Notice on our website at: www.anthem.com/ca
HOW DO YOU CONTACT US TO USE YOUR RIGHTS?

If you want to use any of the privacy rights explained in this Notice, please call or write us at:

Anthem Blue Cross
The phone number for the Customer Care Center printed on your ID card

COMPLAINTS

If you believe that we have not protected your privacy and wish to complain, you may file a complaint (or grievance) by calling, writing or contacting the agencies below:

DHCS Privacy Officer
 c/o Office of Legal Services
 California Department of Health Care Services
 P.O. Box 997413, MS 0011
 Sacramento, CA 95899-7413
 Telephone: 916-440-7750 or
 Email: privacyofficer@DHCS.ca.gov

Or

DHCS Information Security Officer
 Information Security Office
 P.O. Box 997413, MS 6400
 Sacramento, CA 95899-7413
 Email: DHCSiso@DHCS.ca.gov
 Telephone: ITSD Help Desk
 916-440-7000 or
 800-579-0874
USE YOUR RIGHTS WITHOUT FEAR

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

QUESTIONS

If you have any questions about this Notice and want further information, please contact us at the Anthem Blue Cross phone number for Customer Service printed on your ID card.
Primary Care Physician/Provider (PCP) Selection Form

If your ID card does not show the PCP of your choice or if you wish to change your PCP for any reason, please follow these directions:

- If you are a Medi-Cal member, call 1-800-407-4627.
- If you are an L.A. Care Health Plan member, call 1-888-285-7801.
- If you are a Healthy Families Program member, call 1-800-845-3604.

OR

- Complete the form below and return it to Anthem Blue Cross within 30 days.

You may pick one PCP for the entire family or each member may choose his/her own PCP. You must list each family member on the form even if you select the same PCP.

New ID cards will be mailed to you within five (5) days of changing your PCP. Always carry your ID card with you.

☐ Please check this box if you are pregnant.

When completed, fold at dotted lines on back with the Anthem Blue Cross address facing out, tape the top edge to close, and drop this postage-paid form into a mailbox. We do the rest.

(PCP) Selection Form

Please print. See the Provider Directory for the name and number of your first and second choices.

<table>
<thead>
<tr>
<th>Member Name (First and Last)</th>
<th>Certificate Number/ CIN Number</th>
<th>1st Choice PCP Name (First and Last)</th>
<th>Provider Number</th>
<th>2nd Choice PCP Name (First and Last)</th>
<th>Provider Number</th>
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</table>

Your Address

Your City

Your Name (Please Print)

Your Daytime Telephone Number

Your State

Your ZIP code

Your Signature

Choose the PCP that’s right for you. Send this form back today!
Blue Cross of California doing business as Anthem Blue Cross is contracted with L.A. Care Health Plan to provide Medi-Cal managed care services in Los Angeles County. Independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.