What you need to know

Important legal information about your health plan

Anthem BlueCross

52386CAMENABCFI 03/15

Every year we send you important information about your rights, your benefits and more. Going paperless reduces clutter and it's easy to sign up to get these notices by email:

- Log in at **anthem.com/ca**.
- Pick **Profile**.
- Choose **Email Preferences**.
- Select **Primary Email Address**.
- Choose **Save/Update**.

Looking for information about your plan?

Every year we share details about your benefits and rights and responsibilities as a member so you can get the most from your health plan. This information is online, all in one place, and available anytime. Visit **anthem.com/ca** to:

Learn about:

- Your rights and responsibilities
- Covered and noncovered services and benefits that have limitations
- Copayments and any costs you may have to pay
- Steps we take when evaluating new treatments to be considered as covered benefits

Learn how to:

- Access primary and specialty care, behavioral health and hospital services.
- Access care when you are out of the plan's service area.
- Search for doctors, specialists or hospitals in our network, and learn about their qualifications.
- Find a new doctor if you are turning 18 and ready to move to adult care.
- File a claim for covered services.
- Access care after normal office hours.
- Share information about all the care you get with all your doctors

Learn about important programs, such as:

- Our Quality Improvement (QI) program and how we use this information to review and help improve the quality of our benefits and services.
- Our Case Management program and how to sign up if you have a serious medical condition.

Other information you'll find:

- How organ donors save thousands of lives and how to become one.
- What all women need to know about early detection and treatment of cancer.

To find your information, go to: anthem.com/ca/insidemyplan2578.
For a printed copy of this information, call Member Services at the number on your member ID card.

Protecting your privacy

Where to find our Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. We are required by HIPAA to notify you of the availability of our Notice of Privacy Practices. The notice describes our privacy practices, legal duties and your rights concerning your Protected Health Information. We must follow the privacy practices described in the notice while it is in effect (it will remain in effect unless and until we publish and issue a new notice).

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment or billing.

You may obtain a copy of our Notice of Privacy Practices on our website at **anthem.com/ca** or you may contact Member Services using the contact information on your identification card.

State notice of privacy practices

As we indicate in our HIPAA Notice of Privacy Practices, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI is information that identifies a person and is often gathered in an insurance matter.

If we use or disclose PI for underwriting purposes, we are prohibited from using or disclosing PI that is genetic information of an individual for such purposes. We may collect PI about you from other persons or entities such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt out of that activity, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

Please contact your administrator or call Member Services at the number on your insurance identification card for more information.

For the Women's Health and Cancer Rights Act, the federal DOL website has this information: **dol.gov/ebsa/publications/whcra.html**.

Anthem Blue Cross Formulary

What is the Anthem Blue Cross Drug List?

Anthem Blue Cross has a list of prescription drugs that we prefer to use as the first line of therapy (treatment). We call this the outpatient prescription drug list. Only a treating doctor can decide what drugs are best for you. To find out more about this drug list:

- Call the number on your member ID card.
- Visit **anthem.com/ca**.
- Check your Evidence of Coverage for benefits and drugs that are limited or excluded.

Pharmacy benefits that need a prior OK

Some drugs require an OK before they can be prescribed. This is called Prior Authorization. Each quarter, Anthem Blue Cross reviews trends in pharmacy use to find drugs that should be part of the Prior Authorization of Benefits (PAB) program.

Who decides which drugs are part of the PAB program? A Formulary Review Committee – a group of doctors and pharmacists – sets rules and approve guidelines for pharmacy. They make sure the guidelines reflect both the Food and Drug Administration's (FDA) standards and community prescribing standards, and add value to the drug benefit. If a drug is prescribed outside of FDA guidance, we have a policy to allow coverage of the drug when medically necessary.

Step therapy explained

Some drugs are best used as a second choice after other drugs have been tried (ones we call first-line therapy). These medications are noted as step-therapy products. Here's how it works:

- A prescription for a step-therapy drug is given to the pharmacy.
- The online claims processor searches past claims for first-line therapy.
  - **If the member has already tried a first-line therapy, the claim will be processed automatically.**
  - **If a first-line therapy has not been tried, the claim will be rejected. The pharmacist should either call the plan or the doctor to talk about other prescription options.**
- Finally, a small number of drugs may be limited to use in certain age or gender groups. They may have to go through the PAB process for benefit coverage. Your prescribing doctor can fax prescription drug PAB requests to **1-888-831-2243**.

How long it takes for PAB drug requests

Urgent PAB requests	Within 24 hours of getting request • 72 hours if extra information is needed or doesn't meet approval criteria
Nonurgent PAB requests	Within two days if all needed information is given • Five business days if extra information is needed or doesn't meet the approval criteria
Notification of decision	24 hours for prescribing doctor. Two business days for members

What happens if a PAB request is denied? We will send a letter to the prescribing doctor telling the medical reason(s) for the denial with the name of the Anthem Blue Cross doctor who made the denial. We explain how to appeal the decision in the letter to the doctor and in a letter to the member.

What happens when information is missing from a PAB request? In some cases, drug requests are given without all the information we need to make a decision. When this happens, the prescribing doctor may be asked to give extra medical information so we can complete the review within 45 days. We will not make a decision until we get that extra information or the 45-day time period ends. If we don't get the requested information in the required time frame, a decision is made based on what is available.

The Anthem Blue Cross PAB process is reviewed regularly to make sure we have timely results. In emergency cases or life-threatening situations, a 72-hour supply of a drug may be given to members. Call **1-888-831-2242** to find out the status of a PAB request. To get PAB Request forms or a list of PAB drugs, call the number on your member ID card.

Covering drugs not on the list

We support your doctor's decision about what prescription drugs you need. In most cases, if you need a drug not on the drug list or not on the preferred drug list, your doctor can write "do not substitute" or "dispense as written" on the prescription. The prescription will be processed at the pharmacy. You may have to pay a higher cost, depending on your benefit. For some drugs, your doctor will need to begin the PAB process and we require an internal review.

What are quantity limits?

Most pharmacy benefits allow up to a 30-day supply of a drug for the cost you pay out of pocket. We call this either a copay or coinsurance. Sometimes we set a quantity limit based on what the FDA recommends. If a drug has a quantity limit, it's part of the Quantity Supply Program. If a medical condition requires a greater supply than what's recommended, then PAB makes sure the member gets an appropriate quantity. Drugs in this program require an internal review by Anthem Blue Cross before being filled.

To learn more about quantity limits, call the number listed on your member ID card. You can also:

- Go to **anthem.com/ca**.
- Choose **Prescription Benefits** under **Useful Tools** on the **anthem.com/ca** home page and log in.
- On the **Pharmacy** page, choose **Printable Drug Lists** under **Other Pharmacy Resources**.

Note: Pharmacy management procedures apply to fully insured client and ASO members who have opted into the program.

Dose optimization

The Dose Optimization Program is a part of the Quantity Supply Program. It helps patients stick to drug therapies. This program works with you, the member, your doctor or health care provider and pharmacist to replace multiple doses of a lower-strength drug (where appropriate) with a single dose of a higher-strength drug. That is what dose optimization means. We do this only with the prescribing doctor's approval. To learn more, call the number on your member ID card.

Note: Pharmacy management procedures apply to fully insured client and ASO members who have opted into the program.

Need more details about pharmacy benefits?

Find a Pharmacy

To find a local pharmacy, please call the number listed on your member ID card. You can also search online:

- Go to **anthem.com/ca**.
- Choose **Find a Doctor** in the Useful Tools section on the home page.
- Under Step 1, select **Pharmacy**.
- Under Step 2, enter the pharmacy name (optional).
- Under Step 3, select the distance and city, state and ZIP code. Or enter the address, state and county (optional).
- Under Step 4, enter the first three letters of your member ID. You can also select your state, plan type and plan name. Or you can search all plans.

Look up drugs online

It's easy to look up pricing and coverage online:

- Visit **anthem.com/ca**.
- Choose **Prescription Benefits** and log in.
- On the Pharmacy page, choose **Price a Medication**. You'll navigate to the website of our pharmacy benefits manager, Express Scripts.
- In the **Price a Medication** tool, enter a drug name to find its cost (including dose, quantity, and days' supply), and other choices that may save you money are included in the results.

Manage Your Prescriptions

To manage your prescription orders online, visit **anthem.com/ca**, choose **Prescription Benefits** in the **Useful Tools** section and then log in:

- On the Pharmacy page, choose an option in the **Pharmacy Self Service** section. You'll be directed to our pharmacy benefit manager's website.
- Manage your prescription orders in the **My Prescriptions** section on the left side of the page.
- You can see prescription order refills, check order status and even view your history.

See your Evidence of Coverage for the pharmacy programs and benefits that apply to your health plan.

Grievance and appeal

How to file a grievance or appeal a decision

This process applies if you're covered by Anthem Blue Cross or Anthem Blue Cross Life & Health Insurance Company (Anthem). To find out, check your member ID card.

If you're unhappy with the care or service you received from Anthem or a contracting medical group or health care provider, you can file a complaint (we call this a "grievance"). If you disagree with a denial of treatment or payment of a claim, you can "appeal" the decision.

You have up to 180 calendar days from the date you get a denial notice or the date of an incident or dispute to file a grievance or appeal unless your plan documents state otherwise. If there's a good reason, we may extend the time frame for filing a grievance or appeal.

Submitting a grievance or appeal:

- **Member Grievance Form:** Complete a Member Grievance form and mail it to:

  Anthem Blue Cross,
  Attn: Priority Member Grievances,
  PO Box 60007, Los Angeles, CA 90060-0007.

  The form is available from your medical group, on our website or by calling Member Services at the number on your member ID card.

- **Website:** Go to **anthem.com/ca**. and download the grievance or appeal form. You can find it under the heading **Customer Care**, you will see "I need to." Under that, choose **File an appeal or grievance**.
- **Customer Service:** Call Member Services at the number on your member ID card to file a verbal grievance or appeal.

For emergency complaints

For any emergency grievance or appeal, please call Member Services right away at the number on your member ID card.

You can choose a representative like an attorney or health care expert to file a grievance or appeal for you. You'll be asked to complete and sign an authorization form so that person can represent you.

What to include with your appeal

- The member's name and ID number
- The name of the provider or facility that provided care
- The date(s) of service
- The claim or reference number for the specific decision with which you do not agree
- The reason(s) why you don't agree with the decision

You have the right to submit written comments, documents or other key information with your appeal. We encourage you to do so.

What happens next?

- The appropriate administrative and/or clinical specialists will review all the information you or your representative submit with your appeal. Anthem reviewers cannot have been involved in the initial decision. They also can't work for the person who made the initial decision.
- We may contact any providers who may have more information to support your appeal.
- We will send you a written decision within 30 calendar days of getting your grievance or appeal. If your condition is urgent, you can ask for an expedited review of your grievance or appeal. Anthem will then provide you with a written decision within 72 hours.
- If we deny your appeal, we'll give you other options, including external review, if available. You also can refer to your plan documents or call Member Services at the number on your member ID card to get detailed information about the appeal process.

Speak another language?

We can help you or any member who prefers to speak in a language other than English and those with vision, speech or hearing loss by providing:

- Translation services for letters and written materials (through customer service)
- An interpreter in a language other than English (through customer service)
- Telephone relay systems
- Other devices to aid people with disabilities

For members enrolled in Anthem Blue Cross plans*

The California Department of Managed Health Care 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 **1-800-365-0609** 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 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 Web site hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

For members enrolled in Anthem Blue Cross Life & Health Insurance Company plans*

You may contact: California Department of Insurance
Consumer Affairs Bureau
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357)

*To identify the company that provides your plan, check your member ID card.

What's an Independent Medical Review (IMR)?

As a member, you can apply to the California Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) (whichever applies) for an Independent Medical Review (IMR) within 6 months of a qualifying event. You may request an IMR after filing an appeal with us and:

- The denial is upheld; or
- The appeal remains unresolved after 30 calendar days or after 72 hours for expedited reviews. After receiving an initial denial of investigational treatment, you don't have to go through the Anthem grievance and appeal process before you request an IMR.

When the DMHC or CDI decides your appeal qualifies for an IMR, Anthem provides the requested medical information within required time frames to an Independent Review Organization (IRO) picked by the DMHC or CDI. Anthem must follow the decision of the IRO.

If services are approved, we notify you and your provider in writing within five business days. If services are denied, the DMHC or CDI notifies you in writing, explaining the reason for the denial. Check your Combined Evidence of Coverage and Disclosure for more about grievance procedures and the IMR process.

Attn: ERISA plan members

If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), once you have exhausted all mandatory appeal rights, you have the right to bring a civil action in federal court under section 502(a)(1)(B) of ERISA.

Call customer service

If you or a representative filed a grievance or appeal, you can call Member Services at the number on your member ID card with any questions or requests for information about your case.

UM, UR and medically necessity review

Here's what it all means and how it works

To determine if the health care or service your doctor or other health care provider wants to give you is a "medical necessity," Anthem will review requests for authorization. View your benefit plan to know what makes something "a medical necessity" and when care requires this review.

A "medical necessity review" may be called utilization review (UR), utilization management (UM) or medical management. It is a review process that helps decide if a certain outpatient care, inpatient hospital stay, technology or procedure is medically needed.

Reviews can happen at different times including:

- When a service, treatment or procedure is asked for or planned ahead. We call this prospective or pre-service review.
- During the course of care. We call this inpatient or outpatient ongoing care review.
- After care or services have been given. We call this retrospective or post-service review.

With so many different things to consider, it may help to get a clear picture of what to expect and how the process works.

Timing matters

We're committed to deciding cases quickly. Here are several time frames you can expect:

Type of review	The maximum time allowed for a health plan to decide medical necessity once it gets the information needed to do so
Nonurgent pre-service (before care)	Five business days
Urgent pre-service (before care)	72 hours
Urgent inpatient or outpatient ongoing care (during care)	24 hours (in specific instances) no later than within 72 hours of getting a request
Retrospective/post-service (after care)	30 calendar days

What happens if there is a delay?

If we don't have the information we need to make a decision, we try to get it from the doctor or other health care provider who requests the service or care.

We'll write you and the requesting doctor or health care provider if there might be a delay because the information we need is not easy to get. This letter tells you what we need to make a decision and when to expect the decision once we get the information.

If we don't get the information we need, we will send a final letter explaining that we are unable to approve access to this benefit due to lack of information.

Professional reviewers decide

Qualified licensed health care professionals and doctors from Anthem Blue Cross and the medical group (or their peers) review requests and give an opinion specific to a medical condition, procedure and/or treatment under review. If the reviewer is unable to decide the medical necessity of a request, he or she may call the requesting doctor or other provider to discuss the case. In many cases, medical necessity can be determined after this call.

Decisions are based on what is right for each member for the type of care and service. Medically necessary review decisions made by Anthem Blue Cross are based on:

- Anthem's medical policy criteria and guidelines (reviewed at least once a year and updated as standards and technology change).
- Nationally recognized clinical guidelines approved by a committee including practicing doctors and health care professionals not employed by Anthem Blue Cross.
- Your health benefits.

Associates, consultants or other providers are not rewarded or offered money or other incentives for denying care or a service, or for supporting decisions that result in using fewer services. Anthem doesn't make decisions about hiring, promoting or firing these individuals based on the idea or thought that they will deny benefits.

Medical necessity doesn't mean payment or coverage

If we find services are medically necessary, it doesn't mean the service is paid for or covered. Payment is based on the terms of your coverage at the time of service. There are some exclusions, limitations and other conditions that are part of your benefits. You will find them in your Evidence of Coverage. Payment of benefits could be limited for a number of reasons, such as:

- Information included with the claim differs from that given at time of review.
- The service performed is excluded from coverage.
- You are not eligible for coverage when the service is given.

Decisions not to approve are put in writing

If we find the service is not a medical necessity, you and your doctor or health care provider requesting it will get written notice sent to you within two business days of the decision. This written notice has:

- A clear and simple explanation of the reason for the decision.
- The name of the criteria and/or guidelines used to make the decision and instructions for how to obtain a written copy.
- Information on how to appeal the decision and about your rights to an independent medical review.
- Specific parts of the contract that exclude coverage if the denial is based upon benefit coverage.

To see our guidelines

Anyone can see Anthem Blue Cross' medical necessity guidelines for specific services.

- Go to **anthem.com/ca**.
- Choose **Customer Support** in the upper-right side of the screen.
- Under **Top FAQs** select **Anthem-CA Medical Policies**.
- Choose **For detail around Anthem's Medical Policies**.
- Scroll down and pick **Continue**; you will see the Medical Policies and Clinical UM Guidelines Overview page.
- Select **Medical Policies** or the **UM Guidelines** option in the toolbar.
- Choose the link for the desired search option: **Recent Updates**, **By Category** or **By Alpha**.
- Select the desired Medical Policy or UM Guideline.

You may also call **1-800-794-0838** to request a free paper copy of the guideline used to determine your case. These guidelines are used by Anthem Blue Cross to authorize, change or deny benefits for people with similar illnesses or conditions. Specific care and treatment benefits vary based on individual need and covered benefits.

UM questions? Call us.

To learn more about a UM medical decision, preauthorization requests, the UR review process or if you have questions or issues, call our toll-free number: **1-800-274-7767** Monday through Friday (except holidays) from 7:30 a.m. to 5 p.m. PST.

If you call after hours or don't reach a "live" person during business hours, leave a confidential voice mail message with your name and phone number. We'll return your call no later than the next business day, unless you request another time.

You also can call Member Services at the number on your ID card to ask for an interpreter in your preferred language. They can read UM information in another language or help explain it in your preferred language free of charge.

If you have a hearing or speech loss, dial 711 to use the National Relay Service or one of the numbers below. A special operator will contact Anthem to help with your needs.

- **1-800-735-2929** (English TTY) **1-800-735-2922** (English voice)

To ER or not to ER?

What you need to know about emergency care

When you need care right away, deciding where to go can be a tough call. The emergency room (ER) may seem like a natural choice. But if it's not a true emergency, you might save money and time by going somewhere else. ER wait times are at an all-time high. Plus, an ER visit can be expensive. True emergencies need ER care or a 911 call. But with nonemergencies, we can help you find other options.

What do you do when you need care right away, but it's not an emergency?

Calling your primary doctor is a good first choice. Your doctor probably knows you better than anyone else. But if you can't see your doctor soon enough, or if it's after hours, finding a clinic or urgent care center is another good option. Retail health clinics and urgent care centers can take care of many of the same health issues, illnesses or injuries that an ER can. Most are open weeknights and weekends and you can still be treated by a doctor, nurse or physician assistant. Finding a nonemergency option is easy. Just go to anthem.com/ca/eralt for a listing in your area that can handle your care needs.

If it's not an emergency, try these options:

- **Retail health clinics** (for members with PPO-type coverage) are staffed by health care professionals who give basic health care services to walk-in patients. They are often in major pharmacy or retail stores.
- **Urgent care centers without X-ray** can handle routine care and common family illnesses. They don't require you to be an existing patient or have an appointment.
- **Urgent care centers with X-ray** treat conditions that should be looked at right away but aren't as severe as emergencies. They can often do X-rays, lab tests and stitches.

	What do they treat?	When are they open?
Doctor's office	Routine care and common illnesses	Hours vary depending on office. Appointments usually required.
Retail health clinic (often in pharmacies or grocery stores)	Basic symptoms (such as a cough, sore throat, rash or minor fever)	Often extended hours, including weekends and evenings.
Urgent care center	Conditions that should be looked at right away, but aren't emergencies. They can usually do X-rays, lab tests and stitches.	Often extended hours, including weekends and evenings.
Emergency room	Medical emergencies (including heart attack symptoms, trouble breathing, severe or uncontrollable bleeding, stroke symptoms).	Open 24/7.

Each clinic or center may have different services. Before you go, be sure to call and ask:

- What are your hours?
- Do you have services that I need?
- What age range do you treat?
- Are you in my health plan network?

You can also contact the 24/7 NurseLine at the telephone number listed on your member ID card 24 hours a day, seven days a week. A registered nurse will listen to your questions and concerns and help you decide which type of care makes the most sense.

Now that you understand your options, you'll know what to do next time you're faced with a health problem. Sometimes, the ER will be the right answer. Sometimes it won't. But knowing the difference can save you time and money without sacrificing the quality of your care.

Next time you need care right away

If it's a true emergency, call **911** or go to the ER right away.

If it is not a true emergency:

- Try calling your primary doctor.
- Call our 24/7 NurseLine.
- Visit **anthem.com/ca/eralt**.

Average plan copays:

- ER visit: $150
- Retail health clinics/ urgent care visit: $10-$40

Getting in to see the doctor

We're committed to making sure you have access to the care you need – when you need it. So here's a brief rundown of how long it should take you to get an appointment with a behavioral/mental health and Employee Assistance Program (EAP) provider.

Type of care	Standard waiting time
Emergency care* (call 911 or go to the nearest emergency room)	Immediately
Emergency (not life-threatening)	Six hours
Urgent care that does not need a prior OK by us (this is called prior authorization)	48 hours
Urgent care that does need prior authorization	96 hours
Routine office visit/ nonurgent care appointment	• 15 business days for psychiatrists • 10 business days for a behavioral health care provider who is not a psychiatrist • Five business days for EAP
After-hours care (when a behavioral health or EAP provider's office is closed)	A live person or recorded message for emergency and nonemergency care is available 24 hours a day, seven days a week. You should also be told: • How to reach a behavioral health/EAP provider • When to expect a call back for nonemergent (urgent) matters
In-office waiting room time	You will usually not have to wait more than 15 minutes to see a doctor, nurse or designated assistant.

To learn more about your health care and benefits, please see your Certificate or Evidence of Coverage or call the Member Services phone number on your ID card. You also can call if you are having difficulty getting an appointment within waiting times.

*California law states that health plans follow the "prudent layperson" standard for emergency care. A "prudent layperson" is a person with an average amount of knowledge about medicine. This law does not allow plans to not pay for emergency services, even if the situation was found not to be an emergency though any "prudent layperson" would have believed it to be one. We expect all providers to tell their after-hours answering service that if a caller believes he or she is having an emergency, the caller should be told to dial 911 or go straight to the emergency room. Answering machine instructions must also tell the member to call 911 or go to the emergency room if the caller believes he or she is having an emergency.

Standard waiting times for medical care:

Type of care	Standard waiting time
Nonurgent care appointments with your primary doctor	10 business days
Urgent care appointments that do not need a prior OK (this is called prior authorization)	48 hours
Nonurgent care appointments with specialists	15 business days
Urgent care appointments that do need prior authorization	96 hours
Nonurgent care appointments for ancillary services (for diagnosis or treatment of injury, illness or other health condition)	15 business days
In-office waiting room time	You will usually not have to wait more than 15 minutes to see a doctor, nurse or designated assistant.
After-hours care (when a doctor's office is closed)	A live person or recorded message for emergency and nonemergency care instructions are available 24 hours a day, seven days a week. You should also be told when to expect a call back for nonemergent (urgent) matters.
Emergency care* (call 911 or go to the nearest emergency room)	Immediately
Question for Anthem's customer service by telephone on how to get care or solve a problem, including mental health	10 minutes to reach a live person by phone during normal business hours (our average customer service call is answered in 45 seconds)
Question for a nurse on how to access care or solve a problem	A nurse line is available 24 hours a day, seven days a week; the number can be found on the back of your member ID card.

Preventive Care and Immunization Guidelines:

You can help keep yourself healthy and well by taking some key steps:

- See your doctor for a well-visit checkup at least once a year.
- Bring all your medications, over-the-counter medicines (including herbal remedies) and prescriptions with you to the checkup.
- Ask your doctor if you are up to date with your immunizations and preventive health screening tests.
- Keep a list of your immunizations and preventive health screenings and bring it with you to your annual checkup.
- Make positive changes in your life by not smoking and reducing alcohol and fatty foods.
- Keep fit by exercising daily.

When you visit your doctor, ask what tests are right for you. Anthem Blue Cross has guidelines to help keep you healthy. You can access the guidelines on our website at anthem.com/ca/health-insurance/health-and-wellness/preventive-care#tab3.

Sharing information among your doctors just got easier

Introducing a new way for your doctors to access and share information to help you get the best possible care

So often our members are being treated by more than one doctor. And typically those doctors aren't able to see how the others are treating you. We are participating in a new, innovative solution to make it easier for doctors, nurses and hospitals across California to access your available health records so they can offer you better care. Now doctors will be able to:

- **Share test results.** This can help you avoid getting the same tests.
- **Coordinate medications.** Knowing which drugs you're taking helps avoid dangerous drug interactions. And it lets doctors know what medicines you're allergic to.
- **Access your health information in an emergency.** That means the hospital or emergency room staff will know important information, like what health conditions you have.

How does it work?

It's called Cal INDEX. It's like an "index" of your health history. And Anthem will be participating. So when you see a doctor or have a test, if a claim comes to us, your health record will be updated so participating doctors in Cal INDEX will be able to see a more complete view of your health history.

What do I have to do?

As an Anthem Blue Cross member, you're automatically enrolled. If you want to opt out, just go to **calindex.org/opt-out** or call **1-888-510-7142**.

Please know we know it's important to keep your health data secure, so your personal information is protected using advanced security systems and modern data encryption techniques. We follow all federal and state guidelines for securing your health data and require Cal INDEX to do the same.

Enjoy the newest member benefit – more quality time with your doctors and a better level of care!

Cal INDEX is only available to members living in California

Language assistance program reaches out to Californians

English:

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in your language, first call your health plan's phone number at **866-249-4844**. Someone who speaks your language can assist you. You may also provide your preferred written and spoken languages directly to your health plan. If you provide your language preferences to your health benefit plan, this information will be maintained by your health plan and will be shared with your provider if the provider requests such information. If your preferred written language is one of your health plans threshold languages, you may receive some plan information in your preferred written language. You may update your preferred written and spoken languages to your health plan by calling **866-249-4844**. If you need more help, call the HMO Help Center at **888-466-2219**.

Spanish:
IMPORTANTE: Puede obtener sin costo los servicios de un intérprete para hablar con su médico o plan de salud. Para solicitar un intérprete o información escrita en su idioma, llame primero al número telefónico del plan de salud, al **866-249-4844**. Alguien que hable su idioma puede ayudarlo. Puede indicar su idioma de preferencia directamente al plan de salud. Si lo hace, el plan conservará esta información y la compartirá con su proveedor si este la solicita. Si el idioma de preferencia para el material escrito es uno de los idiomas del plan de salud, puede recibir parte de la información sobre el plan en ese idioma. Para actualizar su idioma de preferencia, llame al plan de salud, al **866-249-4844**. Si necesita más ayuda, comuníquese con el Centro de Ayuda de HMO, al **888-466-2219**.

Japanese:
重要：医師や保険プランとお話しになる際、お客様の言語による通訳を無料で提供いたします。お客様の言語による通訳または書面による情報をご希望の場合、保険プランの電話番号 **866-249-4844** までお電話ください。お客様の言語を話す担当者が対応いたします。また、保険プランまで直接ご希望の言語（書面・会話）を提供していただくこともできます。保険プランまでご希望の言語をお知らせいただきますと、この情報は保険プランにより保持され、プロバイダーから要請があった場合に、プロバイダーに共有されます。ご希望の言語が保険プランの利用言語のひとつである場合、お客様には、プランの情報の一部をご希望の言語にてお受け取りいただけることがあります。書面および会話用のご希望の言語は、保険プラン（**866-249-4844**）までお電話いただくことにより、変更することができます。援助が必要な場合は、HMOヘルプセンター（**888-466-2219**）までお電話ください。

Korean:
중요: 담당 의사 또는 건강 플랜과 대화하기 위한 통역 서비스를 무료로 받을 수 있습니다. 통역사를 요청하거나 귀하 언어로 된 서면 정보에 대해 요청하려면 먼저 귀하 건강 플랜에 **866-249-4844**번으로 전화하십시오. 귀하의 언어를 말하는 사람이 귀하를 도와드릴 수 있습니다. 귀하는 또한 본인이 원하는 서면과 구두 언어를 직접 건강 보험 플랜에 제공할 수 있습니다. 만약 귀하가 건강 보험 혜택에 본인이 원하는 언어를 제공하였을 때 해당 정보는 귀하의 건강 보험에서 보관하며 이런 정보에 대한 귀하의 서비스 제공자 요청으로 제공자와 공유합니다. 만약 귀하가 원하는 서면 언어가 귀하의 건강 보험 플랜에서 제공 가능한 언어 중의 하나일 시 귀하는 본인이 원하는 서면 언어로 된 일부 보험 정보를 받게 됩니다. 귀하는 **866-249-4844**번에 전화하여 본인이 원하는 서면과 구두 언어를 건강 보험 플랜에 업데이트할 수 있습니다. 추가 도움이 필요하시면 HMO 도움센터에 **888-466-2219**번으로 전화하십시오.

Chinese:
重要事宜：您可以透過免費譯員與您的醫師或健保計劃交流。如欲要求譯員服務或索要您母語形式的書面資訊，請首先聯絡您的健保計劃，他們的電話號碼是**866-249-4844**。說您母語的人士會幫助您。您可以直接向您的健保計劃提供您的首選書面和口語語種。如果您向健保計劃提供了您的首選語種，這一資訊將由您的健保計劃保存，如果您的醫療服務提供者需要此類資訊，我們可以告知他們。如果您的首選書面語種是健保計劃可提供的語言，您可以收到以您首選語言書寫的健保計劃資訊。您可以透過撥打**866-249-4844**，向健保計劃更新您的首選書面或口語語種。如果您需要更多幫助，請撥打**888-466-2219**接洽HMO服務中心。

Russian:
ВАЖНО: Мы можем бесплатно предоставить вам устного переводчика для общения с врачом или страховым планом. Если вам нужен устный переводчик или письменный перевод документа на ваш язык, позвоните в свой страховой план, телефон **866-249-4844**. Вам поможет сотрудник, который говорит на вашем языке. Кроме того, о языках, на которых вы предпочитаете говорить и читать, вы можете сообщить непосредственно в свой страховой план. План сохранит ваши языковые предпочтения и будет сообщать о них вашим врачам по их запросу. Если вы предпочитаете получать материалы плана на одном из основных наших языков, мы можем присылать вам некоторые документы плана в переводе на этот язык. Для того чтобы поменять языки, на которых вы предпочитаете говорить или читать, позвоните в свой страховой план, телефон **866-249-4844**. Если вам нужна дополнительная помощь, позвоните в Центр помощи клиентам организаций медицинского обеспечения (HMO Help Center), телефон **888-466-2219**.

Arabic:

هام: يمكنك الحصول على مترجم فوري للتحدث إلى طبيبك أو الخطة الصحية دون تكلفة. وللحصول على مترجم فوري أو السؤال عن معلومات مكتوبة في لغتك، اتصل أولاً على رقم هاتف خطتك الصحية على **866-249-4844**. قد يتمكن شخص ما يتحدث لغتك من مساعدتك. وقد تقدم كذلك اللغات المكتوبة أو المحكية المفضلة لديك مباشرة لخطتك الصحية. في حال قدمت أفضليات لغتك لمزايا خطتك الصحية، سيتم الاحتفاظ بهذه المعلومات عبر خطتك الصحية ومشاركتها مع مقدم رعايتك في حال طلب مقدم الرعاية مثل هكذا معلومات. وفي حال كانت اللغة المكتوبة المفضلة لديك من إحدى اللغات المستجدة في خطتك الصحية، فقد تتلقى بعض المعلومات من الخطة في لغتك المكتوبة المفضلة. وقد تعمل على تحديث اللغات المكتوبة والمحكية المفضلة لديك لدى خطتك الصحية بالاتصال على **866-249-4844**. إذا كنت بحاجة إلى المزيد من المساعدة، اتصل بمركز مساعدة مؤسسة تنسيق خدمات الرعاية الصحية HMO على الرقم **888-466-2219**.

Farsi:

نکته مهم: می توانید برای صبحت کردن با پزشک یا برنامه درمانی خود بطور رایگان از خدمات یک مترجم شفاهی استفاده کنید. برای دریافت مترجم شفاهی یا درخواست در مورد اطلاعات کتبی به زبان خود، ابتدا با برنامه درمانی خود به شماره تلفن **866-249-4844** تماس بگیرید. شخصی که به زبان شما صحبت می کند می تواند به شما کمک کند. شما همچنین می توانید زبان های کتبی و شفاهی مورد نظر خود را مستقیماً به برنامه درمانی اعلام کنید. اگر زبان های ترجیحی خود را به برنامه مزایای بهداشتی اعلام کنید، این اطلاعات توسط برنامه درمانی شما نگهداری خواهد شد و در صورتی که ارائه کننده درخواست چنین اطلاعاتی را داشت، به ارائه کننده اعلام خواهد شد. اگر زبان کتبی ترجیحی شما یکی از زبان های پرکاربرد برنامه های درمانی باشد، ممکن است بتوانید برخی از اطلاعات برنامه را به زبان کتبی مورد نظر خود دریافت کنید. برای تغییر دادن زبان های کتبی و شفاهی ترجیحی خود می توانید با برنامه درمانی به شماره **866-249-4844** تماس بگیرید. اگر به کمک بیشتری نیاز دارید، با مرکز کمک رسانی HMO به شماره **888-466-2219** تماس بگیرید.

Khmer:

ចំណាចសំខាន់ៈ អ្នកអាចទទួលសេវាអ្នកបកប្រែដោយឥតគិតថ្លៃ ដើម្បីនិយាយជាមួយគម្រោងសុខភាព ឬគ្រូពេទ្យរបស់អ្នក។ ដើម្បីទទួលបានអ្នកបកប្រែ ឬដើម្បីស្នើសុំព័ត៌មានសរសេរជាភាសារបស់អ្នក ជាដំបូងសូមហៅទូរសព្ទទៅគម្រោងសុខភាពរបស់អ្នក តាមរយៈលេខ **866-249-4844**។ អ្នកដែលចេះនិយាយភាសារបស់អ្នក អាចជួយអ្នកបាន។ អ្នកក៏អាចផ្តល់នូវជម្រើសភាសាសរសេរ និងនិយាយរបស់អ្នក ដោយផ្ទាល់ទៅកាន់គម្រោងសុខភាពរបស់អ្នក។ ប្រសិនបើអ្នកផ្តល់នូវជម្រើសភាសារបស់អ្នក ទៅកាន់គម្រោងអត្ថប្រយោជន៍សុខភាពរបស់អ្នកនោះ ព័ត៌មាននេះនឹងត្រូវបានក្សាទុកដោយគម្រោងសុខភាពរបស់អ្នក ហើយនឹងត្រូវបានចែករំលែកជាមួយនឹងអ្នកផ្តល់សេវារបស់អ្នក ប្រសិនបើអ្នកផ្តល់សេវានោះស្នើសុំព័ត៌មាននេះ។ ប្រសិនបើជម្រើសភាសាសរសេររបស់អ្នក គឺជាភាសាមួយក្នុងចំណោមភាសាចម្បងរបស់គម្រោងសុខភាពរបស់អ្នកនោះ អ្នកអាចនឹងទទួលបានព័ត៌មានអំពីគម្រោងខ្លះៗជាភាសាសរសេរដែលអ្នកបានជ្រើសរើស។ អ្នកអាចនឹងធ្វើបច្ចុប្បន្នភាពជម្រើសភាសាសរសេរ និងនិយាយរបស់អ្នក ទៅកាន់គម្រោងសុខភាពរបស់អ្នក ដោយហៅទូរសព្ទទៅលេខ **866-249-4844**។ ប្រសិនបើអ្នកត្រូវការជំនួយបន្ថែម សូមហៅទូរសព្ទទៅមជ្ឈមណ្ឌលជំនួយ (Help Center) HMO តាមរយៈលេខ **888-466-2219**។

Hmong:

TSEEM CEEB HEEV: Koj siv tau ib tug neeg txhais lus dawb los pab koj tham nrog koj tus kws kho mob lossis koj qhov kev npaj pab them nqi kho mob. Yog tias koj xav tau ib tug neeg txhais lus lossis xav tau tej yam ntaub ntawv sau ua koj hom lus, hu rau koj qhov kev npaj pab them nqi kho mob tus xovtooj ua ntej ntawm **866-249-4844**. Ib tug neeg uas txawj hais koj hom lus mam li pab koj. Koj kuj qhia tau rau koj qhov kev npaj pab them nqi kho mob tias koj xum tau ntaub ntawv txhais ua hom lus twg thiab koj xum hais hom lus twg. Yog tias koj qhia rau koj qhov kev npaj pab them nqi kho mob tias koj xum siv hom lus twg, koj qhov kev npaj pab them nqi kho mob yuav khaws cov lus no cia thiab lawv yuav qhia rau koj tus kws pab kho mob yog tias tus kws pab kho mob tau nug txog. Yog tias hom koj xav tau ntaub ntawv sau hom ib hom lus uas koj qhov kev npaj pab them nqi kho mob muaj, koj mam li txais tej yam lus qhia txog koj qhov kev npaj them nqi kho mob uas tau muab sau ua hom lus uas koj xum tau. Koj hloov tau tias seb koj xum siv thiab hais hom lus twg thaum koj hu rau koj qhov kev npaj pab them nqi kho mob ntawm **866-249-4844**. Yog tias koj xav tau kev pab ntau zog, hu rau HMO Lub Chaw Pab ntawm **888-466-2219**.

Tagalog:
MAHALAGA: Maaari kayong makakuha ng intepreter nang walang gastos upang makipag-usap sa inyong doktor o planong pangkalusugan. Para kumuha ng interpreter o humingi ng nakasulat na impormasyon na nasa wika ninyo, tawagan muna ang numero ng telepono ng inyong planong pangkalusugan sa **866-249-4844**. Matutulungan kayo ng isang taong nagsasalita ng wika ninyo. Maaari rin ninyong direktang ibigay sa inyong planong pangkalusugan ang mas gugustuhin ninyong nakasulat at sinasalitang mga wika. Kung ibibigay ninyo ang inyong mga kagustuhan sa wika sa inyong plano para sa benepisyo sa kalusugan, pananatilihin ng inyong planong pangkalusugan ang impormasyong ito at ibabahagi ito sa nagbibigay ng serbisyo (provider) sa inyo kung hihilingin ng provider ang ganitong mga impormasyon. Kung ang mas gugustuhin ninyong nakasulat na wika ay isa sa mga pangunahing wika ng inyong mga planong pangkalusugan, maaari kayong makatanggap ng ilang impormasyon ng plano sa mas gugustuhin ninyong nakasulat na wika. Maaari ninyong i-update ang mas gugustuhin ninyong nakasulat at sinasalitang mga wika sa inyong planong pangkalusugan sa pamamagitan ng pagtawag sa **866-249-4844**. Kung kailangan ninyo ng karagdagang tulong, tawagan ang HMO Help Center sa **888-466-2219**.

Vietnamese:
QUAN TRỌNG: Quý vị có thể yêu cầu một thông dịch viên miễn phí để nói chuyện với bác sĩ hay chương trình sức khỏe của quý vị. Để yêu cầu một thông dịch viên hay hỏi về thông tin viết bằng ngôn ngữ của quý vị, đầu tiên hãy gọi đến số điện thoại của chương trình sức khỏe của quý vị theo số **866-249-4844**. Nhân viên nói ngôn ngữ của quý vị có thể trợ giúp quý vị. Quý vị cũng có thể đề nghị trực tiếp các ngôn ngữ nói và viết ưa thích của quý vị với chương trình sức khỏe. Nếu quý vị đề nghị ngôn ngữ ưa thích với chương trình phúc lợi sức khỏe của quý vị, thì thông tin này sẽ được duy trì trong chương trình sức khỏe của quý vị và được chia sẻ với bác sĩ của quý vị nếu bác sĩ yêu cầu thông tin này. Nếu ngôn ngữ viết ưa thích của quý vị là một trong những ngôn ngữ tiêu chuẩn của chương trình sức khỏe, thì quý vị có thể nhận một số thông tin chương trình bằng ngôn ngữ viết mà quý vị ưa thích. Quý vị có thể cập nhật các ngôn ngữ nói và viết ưa thích của quý vị với chương trình sức khỏe bằng cách gọi số **866-249-4844**. Nếu quý vị cần giúp đỡ thêm, xin gọi Trung Tâm Trợ Giúp HMO tại số **888-466-2219**.

Punjabi:
ਮਹੱਤਵਪੂਰਣ: ਤੁਸੀਂ ਆਪਣੇ ਡਾਕਟਰ ਜਾਂ ਹੈਲਥ ਪਲਾਨ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਬਿਨਾਂ ਕਿਸੀ ਮੁੱਲ ਦੇ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪਰ੍ਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪਰ੍ਾਪਤ ਕਰਨ ਲਈ ਜਾਂ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿੱਖਤ ਜਾਣਕਾਰੀ ਪਰ੍ਾਪਤ ਕਰਨ ਲਈ, ਪਹਿਲਾਂ ਆਪਣੇ ਹੈਲਥ ਪਲਾਨ ਨੂੰ **866-249-4844** ਤੇ ਫ਼ੋਨ ਕਰੋ। ਕੋਈ ਅਜਿਹਾ ਵਿਅਕਤੀ ਜੋ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਬੋਲਦਾ ਹੈ, ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਆਪਣੇ ਹੈਲਥ ਪਲਾਨ ਨੂੰ ਸਿੱਧੇ ਤੌਰ 'ਤੇ ਆਪਣੇ ਪਸੰਦ ਦੀ ਲਿੱਖਤ ਅਤੇ ਬੋਲਣ ਵਾਲੀ ਭਾਸ਼ਾ ਬਾਰੇ ਵੀ ਦੱਸ ਸਕਦੇ ਹੋ। ਜੇ ਤੁਸੀਂ ਆਪਣੇ ਹੈਲਥ ਪਲਾਨ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਦੀ ਪਸੰਦਾਂ ਬਾਰੇ ਦੱਸਦੇ ਹੋ ਤਾਂ ਇਹ ਜਾਣਕਾਰੀ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਰਾਹੀਂ ਬਣਾਈ ਰੱਖੀ ਜਾਏਗੀ ਅਤੇ ਤੁਹਾਡੇ ਪਰ੍ਦਾਤਾ ਨਾਲ ਸ਼ੇਅਰ ਕੀਤਾ ਜਾਵੇਗਾ, ਜੇ ਪਰ੍ਦਾਤਾ ਅਜਿਹੀ ਜਾਣਕਾਰੀ ਦੀ ਮੰਗ ਕਰਦਾ ਹੈ। ਜੇ ਤੁਹਾਡੀ ਪਸੰਦਗੀ ਵਾਲੀ ਲਿੱਖਤ ਭਾਸ਼ਾ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਦੀਆਂ ਨੇਮੀ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚੋਂ ਇੱਕ ਹੈ ਤਾਂ ਤੁਸੀਂ ਆਪਣੀ ਪਸੰਦਗੀ ਵਾਲੀ ਲਿੱਖਤ ਭਾਸ਼ਾ ਵਿੱਚ ਕੁਝ ਪਲਾਨ ਜਾਣਕਾਰੀ ਪਰ੍ਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਪਸੰਦਗੀ ਵਾਲੀ ਲਿੱਖਤ ਅਤੇ ਬੋਲਣ ਵਾਲੀ ਭਾਸ਼ਾ ਬਾਰੇ ਆਪਣੇ ਹੈਲਥ ਪਲਾਨ ਨੂੰ **866-249-4844** ਤੇ ਫ਼ੋਨ ਕਰਕੇ ਅਪਡੇਟ ਕਰ ਸਕਦੇ ਹੋ। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਦੀ ਲੋੜ ਹੋਵੇ, ਤਾਂ HMO ਸਹਾਇਤਾ ਕੇਂਦਰ ਨੂੰ **888-466-2219** ਤੇ ਫ਼ੋਨ ਕਰੋ।

Armenian:
ԿԱՐԵՎՈՐ Է. Դուք կարող եք անվճար օգտվել բանավոր թարգմանչի ծառայություններից ձեր բժշկի կամ առողջապահական ծրագրի հետ խոսելու համար: Թարգմանիչ կամ ձեր լեզվով գրավոր տեղեկություններ խնդրելու համար սկզբից զանգահարեք ձեր առողջապահական ծրագրի հեռախոսահամարով՝ **866-249-4844:** Ձեր լեզվով խոսացող որևէ անձ կօգնի ձեզ: Դուք կարող եք նաև տեղեկացնել ձեր առողջապահական ծրագրին ձեր նախընտրելի գրավոր և բանավոր լեզուների մասին: Եթե դուք ձեր առողջապահական ծրագրին հաղորդեք ձեր լեզվական նախընտրություններն, ապա առողջապահական ծրագիրը կպահպանի այդ տեղեկությունը և կփոխանցի այն ձեր մատակարարին, եթե մատակարարը խնդրի այդ տեղեկությունը: Եթե ձեր նախընտրելի գրավոր լեզուն ձեր առողջապահական ծրագրի շեմային լեզուներից մեկն է, հնարավոր է, որ դուք ստանաք ծրագրի որոշ տեղեկատվություն ձեր նախընտրելի գրավոր լեզվով: Կարող եք թարմացնել ձեր նախընտրելի գրավոր և բանավոր լեզուն՝ զանգահարելով ձեր առողջապահական ծրագիր՝ **866-249-4844** հեռախոսահամարով: Եթե ձեզ օգնություն է հարկավոր, զանգահարեք HMO Օգնության կենտրոն՝ **888-466-2219** հեռախոսահամարով:

4361 Irwin Simpson Road
Mason, OH 45040

anthem.com/ca