What you need to know

Important legal information about your health plan

Anthem BlueCross

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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 non-covered 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
- For plans with our pharmacy benefits, your prescription drug plan, drug list/formularies and the pharmaceutical management procedures that may apply

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.
- Get information about accessing emergency care and when to use 911 services.
- 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.
- Voice a complaint or appeal a decision. This includes your right to independent external appeal.
- Get translation services in your preferred language and access TTY/TDD services.
- 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 Utilization Management (UM) process, rules for decision makers, how to contact UM staff toll-free, and our hours of operation
- Our Case Management program and how to sign up if you have a serious medical condition

To find your information, go to www.anthem.com/ca/aboutyourplan3124.
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.

Breast Reconstruction Surgery Benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy
- Surgery and reconstruction of the other breast to provide a symmetrical appearance
- Prostheses and coverage for physical complications during all stages of the covered mastectomy, including lymphedemas

All applicable benefit provisions will apply, including existing deductibles, copayments, and/or coinsurance. Contact your Plan administrator for more information.

For more information about the Women's Health and Cancer Rights Act, you can go to the federal Department of Labor website at **dol.gov/ebsa/publications/whcra.html**

Your prescription drug and pharmacy benefits

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.
- Log in to **anthem.com/ca**.
- Check your Evidence of Coverage for benefits and drugs that are limited or not covered.

Pharmacy benefits that need a prior approval

Some drugs require an approval before they can be prescribed. This is called Prior Authorization. Every three months, 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 is part of the PAB program? A Pharmacy and Therapeutics (P&T) Committee is a group of doctors and pharmacists who sets rules and approves 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 step-therapy 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 a request • 72 hours if extra information is needed or doesn't meet approval criteria
Non-urgent PAB requests	Within 72 if all needed information is given • 5 business days if extra information is needed or doesn't meet the approval criteria
Notification of decision	24 hours for prescribing doctor. 2 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. In letters to the doctor and member, we explain how to appeal the decision.

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 the right quantity. Drugs in this program require an internal review by Anthem Blue Cross before being filled.

Note: This pharmacy management procedure applies to groups who have chosen this program for their employees.

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. We do this only with the prescribing doctor's approval. To learn more, call the number on your member ID card.

Note: This pharmacy management procedure applies to groups who have chosen this program for their employees.

To find out more about the medication coverage information in your drug list, call the number 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 **Select Your Drug List** under *Other Pharmacy Resources*.
- You will be routed directly to the Drug Search page for your benefit-specific drug list

Need more details about pharmacy benefits?

How to find a pharmacy

To find a local pharmacy, call the number on your member ID card. You also can 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

Anthem's new Searchable Drug List Tool provides members with benefit-specific formulary/drug list search capabilities:

- Members can search their drug list for up-to-date information, including:
  - Drug label name
  - Generic drug name
  - Tier status
  - Clinical programs/edits including quantity limits, dose optimizations, prior authorizations and step therapies
  - Generic drug indicator
  - Therapeutic class and category
  - Available dosage/strength options

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.
- Members can manage everything they need to know about their prescription benefits in one place. Using the **Manage Prescriptions** section on the left side of the page, members can:
  - Locate a Pharmacy
  - Price a Medication
  - Check Order Status

Plus, members can access many of the same helpful tools on Anthem's Mobile App. They'll be able to manage all their drug benefits wherever they are, right from their mobile device.

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

How to file a grievance or appeal a decision

What to do if you're unhappy with your care or service

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 network 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 claims payment, 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 say otherwise. If there's a good reason, we may give you more time to file a grievance or appeal.

How to submit a grievance or appeal:

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

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

  This 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.**
- **Member Services:** Call Member Services at the number on your member ID card to file a grievance or appeal.

For emergency complaints

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

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

What to include with your appeal

- Your 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 disagree
- The reason(s) why you don't agree with the decision

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

What happens next?

- The proper 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 original 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 check your plan documents or call Member Services at the number on your member ID card to get more information about the appeal process.

Do you speak another language?

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

- Translation services for letters and written materials (through Member Services)
- An interpreter in a language other than English (through Member Services)
- 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 **800-365-0609**, or at the TDD line **866-333-4823**, 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 number (**888-HMO-2219**) and a TDD line (**877-688-9891**) for the hearing and speech impaired. The department's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online. You may also contact the department by writing to the following address: 980 9th Street, Suite 500, Sacramento, CA 95814 or by e-mail at **helpline@dmhc.ca.gov**.

If you're enrolled in an Anthem Blue Cross Life & Health Insurance Company plan, 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 six 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 ask for 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 IRO's decision.

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.

Are you an ERISA plan member?

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 Member Services

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.

What are utilization management, utilization review and medical necessity review?

Here's what it all means and how it works

To see if the health care or service your doctor or other health care provider wants to give you is a "medical necessity," Anthem looks at requests for authorization. Check 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 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
Non-urgent pre-service (before care)	5 business days 72 hours for non-urgent prescription drug requests
Urgent pre-service (before care)	72 hours 24 hours for urgent prescription drug requests
Urgent inpatient or outpatient ongoing care (during care)	24 hours (in some cases) or 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. It also explains 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 because we don't have enough 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.

Employees, 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. Also, 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 not covered.
- You're 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 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 get 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 the **Medical Policies** or **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 guidelines 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.

Questions about utilization management? Call us.

To learn more about a UM medical decision, preauthorization requests or 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 someone 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 the number below for the California Relay Service. A special operator will contact Anthem to help with your needs.

- **1-800-855-7100** (English TTY/English voice)

To go to the ER or not?

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 when it's not an emergency, we can help you find other options for care.

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 non-emergency care is easy. Just go to **anthem.com/ca/eralt** for a listing of providers 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 longer 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 longer hours, including weekends and evenings.
Emergency room	Medical emergencies (including heart attack symptoms, trouble breathing, severe or uncontrollable bleeding and 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 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. 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 clinic/urgent care visit: $10 to $40

What you need to know about appointments

Getting in to see the doctor when you need mental health or medical care

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)	6 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/non-urgent care appointment	• 15 business days for psychiatrists • 10 business days for a behavioral health care provider who is not a psychiatrist
After-hours care (when a behavioral health or EAP provider's office is closed)	A live person or recorded message for emergency and non-emergency care is available 24 hours a day, seven days a week. The live person or recorded message should also tell you: • How to reach a behavioral health/EAP provider • When to expect a call back for urgent matters that aren't an emergency
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 Customer Service phone number on your ID card. You also can call if you are having difficulty getting an appointment within these 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
Appointments with your primary doctor that aren't urgent care	10 business days
Urgent care appointments that do not need a prior OK (this is called prior authorization)	48 hours
Appointments with specialists for care that is not urgent	15 business days
Urgent care appointments that do need prior authorization	96 hours
Appointments for ancillary services (for diagnosis or treating an injury, illness or other health condition) that is not urgent care	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 non-emergency care instructions is available 24 hours a day, seven days a week. You should also be told when to expect a call back for urgent matters that aren't an emergency.
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
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

Steps to keep yourself healthy

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 diary 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 cutting back on 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 at **anthem.com/ca/health-insurance/health-and-wellness/preventive-care#tab3**.

Free Language Assistance Available

Language Assistance Program Reaches Out to Californians

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. You can also call us at the toll free number on the back of your ID card. To get an interpreter or to ask about written information in your language, first call your health plan's phone number at **888-254-2721**. Someone who speaks your language can assist you. You may also provide your preferred written and spoken language directly to your health plan and directly to your provider. If you provide your language preferences to your health plan, this information will be maintained by your health plan and will be shared with your provider when the provider calls to check eligibility or upon request. If your preferred written language is one of your health plan's threshold languages, you may receive some plan information in your preferred written language. You may update your preferred written and spoken languages and provide information on race and ethnicity to your health plan by calling **888-254-2721**. If you need more help, call the DMHC Help Center at **888-466-2219**.

Traditional Chinese:

重要事宜：您可以透過免費口譯員與您的醫師或健保計劃交流。您也可撥打您保險卡背面的免付費電話號碼與我們聯絡。如欲取得口譯員服務或要求以您語言提供的書面資訊，請首先聯絡您的健保計劃，電話號碼 **888-254-2721**。說您語言的人士能協助您。您也可以直接向您的健保計劃以及您的醫療服務提供者提供您的首選書面和口語語言。如果您向健保計劃提供了您的首選語言，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致電查詢資格情況或需要該資訊，則會將該資訊與其分享。如果您的首選書面語言是您健保計劃可提供的主要語言之一，您則可以收到以您首選書面語言提供的部分計劃資訊。您可以透過撥打 **888-254-2721**，向您的健保計劃更新您的首選書面或口語語言，並提供關於您的民族或種族資訊。如果您需要更多幫助，請撥打 **888-466-2219** 聯絡 DMHC 幫助中心。

Korean:

중요: 담당 의사 또는 건강 플랜과 대화하기 위한 통역사를 무료로 이용하실 수 있습니다. 또한 보험 ID 카드 뒷면에 인쇄된 무료통화 번호를 통해 당사로 전화하실 수도 있습니다. 통역사를 요청하거나 본인이 구사하는 언어로 된 서면 정보를 요청하려면 먼저 귀하 건강 플랜의 번호인 **888-254-2721**번으로 전화하십시오. 귀하 언어를 구사하는 분이 도와드릴 수 있습니다. 또한 귀하가 선호하는 구어, 문어가 무엇인지 직접 본인의 건강 플랜 및 담당 공급자에게 알릴 수도 있습니다. 본인의 건강 플랜에 어떤 언어를 선호하는지 알렸으면 이 정보는 귀하 건강 플랜에 의해 관리되고 공급자가 가입자격을 확인하기 위해 전화하거나 또는 요청 시 이 정보를 해당 공급자와 공유할 수 있습니다. 귀하가 선호하는 문어가 본인 건강 플랜에 준비된 언어 중 하나일 경우, 일부 플랜 정보를 귀하가 선호하는 문어로 받아볼 수 있습니다. **888-254-2721**번으로 전화하여 본인의 건강 플랜에 귀하가 어떤 문어, 구어를 선호하는지 업데이트 하고 인종 및 민족 정보를 제공하실 수 있습니다.추가 도움이 필요하시면 DMHC 도움센터에 **888-466-2219**번으로 전화하십시오.

Spanish:
IMPORTANTE: Puede obtener un intérprete sin costo para hablar con su médico o plan de salud. También puede llamarnos al número de teléfono gratuito que figura al dorso de su tarjeta de identificación. Para obtener un intérprete o consultar por información escrita en su idioma, llame primero al número de teléfono de su plan de salud al **888-254-2721**. Lo asistirá una persona que hable su mismo idioma. También puede informarle directamente al plan de salud o a su proveedor qué idioma escrito y hablado prefiere. Si le informa a su plan de salud qué idioma prefiere, el plan de salud conservará la información y la compartirá con su proveedor cuando este llame para verificar la elegibilidad o si lo solicita. Si el idioma escrito que usted prefiere es uno de los idiomas ofrecidos por el plan de salud, podrá recibir información en ese idioma. Puede cambiar el idioma escrito y hablado que prefiere que use su plan de salud y brindar información sobre su raza y grupo étnico llamando al **888-254-2721**. Si necesita más ayuda, llame al Centro de Ayuda del DMHC, al **888-466-2219**.

Tagalog:
MAHALAGA: Maaari kayong makakuha ng isang interpreter nang walang anumang gastos para sa inyo para kausapin ang inyong doktor o planong pangkalusugan. Maaari rin ninyong tawagan kami sa walang bayad na numero sa likod ng inyong ID card. Para makakuha ng isang interpreter o para humiling ng nakasulat na impormasyon sa inyong wika, tawagan muna ang numero ng telepono ng inyong planong pangkalusugan sa **888-254-2721**. Matutulungan kayo ng isang taong nagsasalita ng inyong wika. Maaari rin ninyong direktang ibigay ang inyong piniling nakasulat at sinasalitang wika sa inyong planong pangkalusugan at sa inyong tagabigay ng serbisyo. Kung ibibigay ninyo ang inyong mga kagustuhan sa wika sa inyong planong pangkalusugan, pananatilihin ng inyong planong pangkalusugan ang impormasyong ito at ibabahagi ito sa inyong tagabigay ng serbisyo kapag tatawag ito upang tingnan ang pagiging karapat-dapat o kapag hiniling. Kung ang inyong piniling nakasulat na wika ay isa sa mga pangunahing wika ng inyong planong pangkalusugan, maaari kayong makatanggap ng ilang impormasyon ng plano sa inyong piniling nakasulat na wika. Maaari ninyong i-update ang inyong piniling nakasulat at sinasalitang wika at maaari kayong magbigay ng impormasyon tungkol sa lahi at etnisidad sa inyong planong pangkalusugan sa pamamagitan ng pagtawag sa **888-254-2721**. Kung kailangan ninyo ng karagdagang tulong, tawagan ang DMHC 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 chăm sóc sức khỏe của quý vị. Quý vị cũng có thể gọi cho chúng tôi theo số miễn cước ở phía sau thẻ ID 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 chương trình chăm sóc sức khỏe của quý vị theo số **888-254-2721**. Nhân viên nói ngôn ngữ của quý vị có thể trợ giúp quý vị. Quý vị cũng có thể cung cấp các ngôn ngữ nói và viết ưa thích của quý vị trực tiếp với chương trình chăm sóc sức khỏe và nhà cung cấp của quý vị. Nếu quý vị cung cấp ưu tiên ngôn ngữ cho chương trình chăm sóc sức khỏe của quý vị, thì thông tin này sẽ được duy trì bởi chương trình chăm sóc sức khỏe của quý vị và sẽ được chia sẻ với nhà cung cấp của quý vị khi nhà cung cấp gọi để kiểm tra tính đủ điều kiện hay theo yêu cầu. Nếu ngôn ngữ viết ưa thích của quý vị là một trong những ngôn ngữ tiêu chuẩn của chương trình chăm sóc sức khỏe, thì quý vị có thể nhận một số thông tin chương trình bằng ngôn ngữ viết ưa thích của quý vị. Quý vị có thể cập nhật các ngôn ngữ nói và viết ưa thích và cung cấp thông tin về chủng tộc và dân tộc của quý vị với chương trình chăm sóc sức khỏe của mình bằng cách gọi số **888-254-2721**. Nếu quý vị cần giúp đỡ thêm, hãy gọi cho Trung Tâm Trợ Giúp DMHC theo số **888-466-2219**.

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