

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) 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.

Receive timely customer service. You have the right to wait no more than 10 minutes to speak to a customer service representative during L.A. Care's normal business hours.

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).



Anthem Blue Cross Member Services Department
toll-free **1-888-285-7801**

L.A. Care Health Plan Member Services Department
toll-free **1-888-839-9909**

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.

Talk to a Registered Nurse any time, day or night, about health questions or worries about symptoms.

L.A. Care provides free telephone health question advice 24/7. The number for your Nurse Advice Line is 1-800-224-0336.

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, go to www.lacare.ethicspoint.com, or you could call the California Department of Health Care Services (DHCS) Medi-Cal Fraud & Abuse Hotline toll-free at 1-800-822-6222.

Medi-Cal Member Handbook

...a helpful guide to getting services

(Combined Evidence of Coverage & Disclosure Form)

L.A. Care Health Plan

1055 West 7th Street

Los Angeles, CA 90017

Toll-free: 1-888-839-9909

T*TY/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.

Web site address: www.lacare.org

Anthem Blue Cross

P.O. Box 9054

Oxnard, CA 93031-9054

1-888-285-7801

1-888-757-6034

Office Hours: Monday thru Friday 7 a.m. to 7 p.m.

Web site address: www.anthem.com/ca

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WELCOME: Thank you for choosing L.A. Care Health Plan!

L.A. Care Health Plan 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 Health Plan 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 over one million members in Los Angeles County. We only serve people who live in Los Angeles County (called our “service area”). L.A. Care 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 up 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 four (4) 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 any Health Plan Partner listed below as long as the plan choice is available:

- Anthem Blue Cross
- Care1st 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

WELCOME: Thank you for choosing L.A. Care Health Plan!

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 health maintenance organization (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.



Anthem Blue Cross Member Services Department
toll-free **1-888-285-7801**

L.A. Care Health Plan Member Services Department
toll-free **1-888-839-9909**

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 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)

Զանգահարեք Anthem Blue Cross, եթե ցանկանում եք ձեր ձեռնարկը այս լեզվով: (Armenian)

如果您想取得後述語言的手冊，請致電 Anthem Blue Cross。 (Chinese)

اگر این دفترچه را به این زبان می خواهید به Anthem Blue Cross زنگ بزنید (Farsi)

សូមទូរស័ព្ទទៅ Anthem Blue Cross បើលោកអ្នកចង់បានសៀវភៅកម្រិតណែនាំសមាជិកនេះជាភាសាខ្មែរ។ (Khmer)

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

Tumawag sa Anthem Blue Cross kung kailangan mo ang handbook sa lengguwaheng ito. (Tagalog)

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.

This Member Handbook: Why is it important to you?

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 the Nurse Advice Line 24 hours a day, 7 days per week when:

- You or a covered family member isn't feeling well and you aren't sure if a doctor is needed.
- You have a question about a medication.
- You have a general question about you or a covered family member's health.

The number is listed on the back of your Anthem Blue Cross ID Card.

You can call **Anthem Blue Cross** when you:

- Need a new ID card
- Want to change your PCP
- Have questions about services and how to get them
- Want to know what is covered or what is not covered
- Need help getting the care you need
- Get a bill from a doctor
- Are pregnant
- Have a problem you can't solve

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

You can call **L.A. Care** 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 www.lacare.org

Do you use the Internet? Our Web site, www.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 www.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.



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L.A. Care Health Plan Member Services Department
toll-free **1-888-839-9909**

Let's get started: How do I get health care?

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

You were asked to choose a PCP and a Health Plan Partner when you filled out the Medi-Cal enrollment form. Sometimes we can't give you the PCP 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 or health plan you chose, call L.A. Care at 1-888-839-9909 to see if that PCP or health plan is available.

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

Members with Medi-Cal and Medicare coverage

Members who receive both Medicare and Medi-Cal benefits **may** not need to choose or be assigned a PCP with L.A. Care.

If you have both Medicare and Medi-Cal benefits, Medicare is your main coverage. You will still go to your Medicare doctors, specialists, hospitals and get most of your prescriptions from Medicare. L.A. Care will work with your Medicare doctor to provide you with any Medi-Cal services you may need.

This handbook explains your Medi-Cal benefits through L.A. Care. L.A. Care will take care of your copayments, medical services and supplies that are not covered by Medicare.

In order for L.A. Care to cover a service, the service must be:

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

Your PCP

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

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

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

Start getting care now! Call your PCP 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 today to make an appointment for a "new member checkup."** This visit is also called a "well visit" or "initial health assessment." Your PCP's telephone number is on your L.A. Care/Anthem Blue Cross ID card.

This first visit is important. Your PCP 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 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.

Let's get started: How do I get health care?

How to see your PCP

1. Call your PCP's office to schedule an appointment. You should get an appointment to see your PCP within 10 business days from the date of your call. Your PCP'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's office.
3. If you can't go to your appointment, call the PCP'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'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, your PCP (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's office is closed

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

You can also call the Nurse Advice Line number at 1-800-224-0336. 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 evaluated 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's doctors have urgent care hours in the evening, on weekends or during holidays.

If you get a bill

Anthem Blue Cross pays for all medical costs covered by Medi-Cal or for emergency care. 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 or hospital stops sending you a bill.

You may get a medical bill if you go to a doctor or hospital that does not work with Anthem Blue Cross or is located outside of L.A. County. If this happens, 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 due to 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.



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L.A. Care Health Plan Member Services Department
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Let's get started: How do I get health care?

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 or Anthem Blue Cross. If your doctor sent your information to a collection company for covered services that you received when you were eligible for Medi-Cal and 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 time they found out about your Medi-Cal to correct it or have it deleted.

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 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's network, then Anthem Blue Cross will authorize (or okay) a second opinion by a qualified health care professional outside Anthem Blue Cross's network.

How to get a second opinion

To get a second opinion:

1. Talk to your PCP, specialist or Anthem Blue Cross and let them know you would like to see another doctor and the reason why.
2. Your PCP, specialist or Anthem Blue Cross will refer you to a qualified health care professional. If you are requesting a second opinion about a diagnosis that your PCP made, the second opinion shall be from a PCP of your choice from the same physician organization as your PCP's. If you are requesting a second opinion about a diagnosis that your specialist made, a second opinion must come from any independent physician association (IPA) or medical group within 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.

Let's get started: How do I get health care?

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 or Ob/Gyn to make an appointment. You should get an appointment to see your PCP or Ob/Gyn within ten (10) calendar days from the date of your call. When you are pregnant, it is important to get care right away, throughout your pregnancy, and after you give birth.

How to get health care that your PCP can't give you

Sometimes you need care your PCP 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 must authorize (or okay) the care, and give you a "referral." A referral is a request from your PCP to another doctor or to the hospital for health care services or treatment you may need. Your PCP will start the referral process. You **MUST** get a referral **BEFORE** you get specialized health care services or treatment at a hospital (you do not need a referral 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 longer if more information is needed from your PCP. In some cases, your PCP 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 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 in Mexico or Canada 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's 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 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 would, based on his or her skill, training and the treatment plan.



Anthem Blue Cross Member Services Department
toll-free **1-888-285-7801**

L.A. Care Health Plan Member Services Department
toll-free **1-888-839-9909**

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's name (or the name of your clinic or medical group)
- Your PCP'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 1-888-285-7801 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 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’s network by calling Anthem Blue Cross and asking for a provider directory.

In most cases, you need to get care within Anthem Blue Cross’s network. That is not the case if you need emergency care or need urgent care in Mexico, Canada or 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 gives you most of your care

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

How to change your PCP

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

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

It is best to stay with the same PCP. Your PCP gets to know your health history and health needs. If you can’t stay with the same PCP, 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.

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

Things to remember if you choose a new PCP:

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

The PCP 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).



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Our provider network: Who gives me health care?

Kinds of PCPs

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

- Family Practice
- General Practice
- Internal Medicine
- Pediatricians
- Ob/Gyns (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 by your health plan 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's Member Services to ensure you can get the health care services you need.

Choosing a Federally Qualified Health Center (FQHC) as your PCP

A Federally Qualified Health Center (FQHC) is a clinic and can be your PCP. 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 is the doctor who makes sure you get the care you need when you need it. Sometimes your PCP will send you to a specialist. A "specialist" is a doctor who is an expert in a certain kind of health care. These specialists are within your PCP and Anthem Blue Cross's network. If you need care from a specialist, your PCP must approve these services before you receive them. Routine referrals to a specialist take up to five (5) business days, but may take longer if more information is needed from your PCP. In some cases, your PCP may ask to "rush" your referral. Expedited (rush) referrals (for when you need medical care right away or have an urgent condition) may not take more than three (3) calendar days.

Female members who need Ob/Gyn care don't need their PCP'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 may be available outside of Anthem Blue Cross's network with prior authorization. To find out more, ask your PCP or call Anthem Blue Cross.

Certified Nurse Practitioners

Some PCPs 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 or call Anthem Blue Cross.

Our provider network: Who gives me health care?

What care can you get from a provider who is not your PCP?

There are some kinds of care that you can get from someone other than your PCP:

- **Emergency care.** In an emergency, dial 911. Emergency services do not need a referral or an okay from your PCP 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 if you are not sure how to get urgent care when you are not in Los Angeles County. Your PCP 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'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 will send you to a specialist if you need one. In most cases, you can't see a specialist without your PCP's okay.
- Members may see an in-network Ob/Gyn for Ob/Gyn services without the PCP'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.



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Our provider network: Who gives me health care?

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's 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's network and within Los Angeles County. However, you can get emergency care or urgent care in Mexico, Canada or outside Los Angeles County.

If you get care from a non-contracted provider (a doctor or other provider that is not a part of Anthem Blue Cross's 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 prior authorization is not needed.

“Prior authorization” means that your PCP and Anthem Blue Cross agree that services and care are necessary. You must have a prior authorization before you get most services or care, such as services from a specialist.

Services that do not require prior authorization are:

- PCP visits
- Emergency services
- Urgently needed services when outside of Los Angeles County
- Family planning services
- Preventive services
- Sexually transmitted disease (STD) services
- HIV testing
- Basic prenatal care from 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



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What is covered: What kinds of health care can I get from Anthem Blue Cross?

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 Papilloma Virus (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.

What is covered: What kinds of health care can I get from Anthem Blue Cross?

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

- Severe pain
- Placing the health of a pregnant woman or her unborn child in jeopardy
- Sudden serious illnesses or symptoms
- Injury or conditions requiring immediate diagnosis and treatment, including emergency labor and delivery

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
- Clinics
- Certified Nurse Midwives and Certified Nurse Practitioners
- Ob/Gyn specialists (doctors who specialize in female reproductive health care)
- Planned Parenthood clinics



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What is covered: What kinds of health care can I get from Anthem Blue Cross?

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 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's network. You do not need an okay from your PCP 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 resources 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 you manage chronic diseases.

Learn more about the topics listed below by talking to your doctor or through health education services:

- Asthma
- Breastfeeding
- Dental Health
- Diabetes
- Drug and Alcohol Programs

- Exercise/Fitness
- Family Planning/Birth Control
- Healthy Foods
- High Blood Pressure
- High Cholesterol
- HIV
- Immunization (Shots)
- Injury Prevention
- Mental Health
- Parenting/Child Health
- Prenatal Health
- Safety Tips
- Sexually Transmitted Disease (STD) Prevention
- Tobacco Use (how to quit or prevent smoking)
- Violence/Abuse
- Weight Problems

Health education services include:

- Written materials (booklets)
- Nurse Advice Line
- 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

Health education services also include:

- Group appointments
- Individual phone consultation
- Referrals to community based health education programs

What is covered: What kinds of health care can I get from Anthem Blue Cross?

- *Health In Motion™* [for L.A. Care Members Only] offers helpful, yet fun, health classes just for our members. Our classes are interactive and exciting so that you learn the skills you need to meet your health goals. We work with your doctor to have these classes at his or her office. If they do not have the space, we will find another place to hold the class near your home. We have classes on nights or weekends. They are in English and Spanish and interpreters can be there for other languages. If you cannot make a class, one of our health educators will call you and talk to you over the phone.
- *Health In Motion™* [for L.A. Care Members Only] also offers weight control programs for all ages. There are classes for members 2-5 years old to start healthy habits early. There are also classes for older kids and teens. The classes teach ways to eat healthy and stay active. Adult members who qualify may get local Weight Watchers® meeting coupons (L.A. Care Health Plan Weight Watchers® Program is for MCLA members who are 18 years old or older).
- For health education services information, visit L.A. Care online at www.lacare.org. You can also visit Anthem Blue Cross Web site at www.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 or health plan for confidential HIV testing. Examples of where you can get confidential HIV testing include:

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

Please call 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 Licensed Vocational Nurses
- 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.



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What is covered: What kinds of health care can I get from Anthem Blue Cross?

Hospice Care

Hospice Care is limited to members who have been certified as terminally ill and are expected to live six (6) 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 and an unlimited number of subsequent periods of 60 days each during the individual's lifetime.

If you are under the age of 21, Anthem Blue Cross will offer and pay for covered services related to your terminal illness even if you choose to receive hospice care.

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.

What is covered: What kinds of health care can I get from Anthem Blue Cross?

Go to “Women, Infants and Children Program (WIC)” 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 or from other qualified providers not with Anthem Blue Cross’s network.

The following services are covered:

- Counseling and surgical procedures to end pregnancy (abortion)
- Drug and alcohol abuse services for members 12 years of age or older
- Family planning
- Pregnancy related services
- Sexual assault treatment (including rape)
- Sexually transmitted disease (STD) services for members 12 years of age or older including consenting to medical care to prevent a sexually transmitted disease.
- Outpatient mental health treatment and counseling for minors (12 to 21 years of age) who are mature enough to participate, and 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, but are not limited to:

- Phenylketonuria (PKU)
- Galactosemia
- Hypothyroidism
- Hemoglobinopathies



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What is covered: What kinds of health care can I get from Anthem Blue Cross?

- 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 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 (TMJ) 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.

What is covered: What kinds of health care can I get from Anthem Blue Cross?

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 a member reasonably believes it was 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, 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 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 is excluded.

Vision Care

Eye exams are covered by Anthem Blue Cross for members of all ages. Members who are under 21 years of age, pregnant or living in a nursing home are covered for one pair of eyeglasses every two (2) years unless the prescription changes. This includes lenses and covered frames for eyeglasses when authorized.

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

X-ray Services

These services will be provided when ordered by your doctor from a network:

- Doctor’s office
- Hospital
- Laboratory



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toll-free **1-888-285-7801**

L.A. Care Health Plan Member Services Department
toll-free **1-888-839-9909**

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 (CHDP)

Your child may get CHDP 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 Program (WIC)

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

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 Web site at www.ihs.gov to find out more.

Medi-Cal benefit changes

The state does not cover some benefits from the Medi-Cal program. These changes only affect some adults age 21 and older who are on Medi-Cal.

However, L.A. Care considers five (5) benefits the state does not cover are important to our members and will still provide these benefits when there is a medical need for all members including members age 21 and older on Medi-Cal.

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.

More benefits: What other services can I get?

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



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More benefits: What other services can I get?

Specialized mental health services may be needed for services beyond your PCP'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.

Anthem Blue Cross will coordinate and cover laboratory, radiological and radioisotope services needed for the diagnosis, treatment and monitoring of a mental health condition. Anthem Blue Cross or regular (fee-for-service) Medi-Cal cover mental health drugs listed on the formulary and prescribed by your PCP or by a licensed mental health provider authorized to prescribe drugs. If medically necessary, you can also get a mental health drug not listed on the formulary. Go to a network pharmacy to fill your prescription. You can learn more about this in the "Pharmacy benefits: How do I get prescription drugs?" section of this handbook.

- Prayer or spiritual healing
- State laboratory services under the state Serum Alpha-fetoprotein Testing Program
- Home and Community Based Services Waiver Program provides services beyond those that are covered by Medi-Cal. These services allow individuals to remain in a community setting rather than be admitted to a long-term care facility.

Non-covered services: What Medi-Cal does 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
- Eyeglasses

If you have questions about what is covered or not covered, please call Anthem Blue Cross.



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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's 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 1-888-285-2801 for pharmacies in your neighborhood. You can also call the Nurse Advice Line at 1-800-224-0336 for answers to questions about a medication.

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 current L.A. Care/ Anthem Blue Cross ID card.
4. Make sure you give the pharmacy your current address and phone number.
5. Make sure the pharmacy knows about all medications you are taking and/or any allergies you have to any medicine.

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

You should not be asked to pay for covered prescription drugs. Call 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's 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.

Brand Name/Generic Drugs

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

Generic versions of drugs must be dispensed, unless a documented medical reason prohibits the use of the generic version. Your doctor must contact Anthem Blue Cross to get an okay to dispense a brand name drug.

Pharmacy benefits: How do I get prescription drugs?

Drugs not on the formulary

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

To decide if this drug will be covered, Anthem Blue Cross may ask your PCP or the pharmacist (or both) for more information. Within 24 hours after getting this information, Anthem Blue Cross will tell your PCP or the pharmacist if the drug will be covered. Your PCP 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
- Limited supply of prescription drugs you get from a pharmacy not in Anthem Blue Cross’s network when you have an emergency
- Only non-prescription drugs or over-the-counter drugs (such as cough/cold syrups, or aspirin) listed on the Anthem Blue Cross formulary
- Formulary diabetic supplies: insulin, insulin syringes, glucose test strips, lancets and lancet puncture devices, pen delivery systems, blood glucose monitors including monitors for the visually impaired, and ketone urine testing strips
- FDA-approved birth control devices, birth control pills, diaphragms, condoms and contraceptive jellies on the Anthem Blue Cross formulary

- Anti-rejection medication for up to two years following an organ transplant, unless during that period the member has private health insurance or becomes eligible for Medicare or private health insurance covering the medication.
- 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



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Pharmacy benefits: How do I get prescription drugs?

- Non-formulary 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)
- Infertility drugs.

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 coverage. 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 www.medicare.gov on the Internet.

Emergency and urgent care: How do I get care in an emergency?

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

How to get urgent care

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

You may also call the Nurse Advice Line at 1-800-224-0336, 24 hours a day, 7 days per week.

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

What is emergency care?

Emergency services are covered anywhere in the United States and in Mexico and Canada— 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



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Emergency and urgent care: How do I get care in an emergency?

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

What to do in an emergency

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

Outside of Los Angeles County?

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

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

You may need hospital care after an emergency to stabilize your condition. This is called post-stabilization care. If you do, the hospital will call 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 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 you PCP 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. Do what your PCP 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.**

Not sure what kind of care you need?

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

- They can answer questions about a health concern and instruct you on self-care at home if appropriate
- They can advise you about whether you should get medical care and how and where to get care (for example, if you are not sure whether your condition is an emergency medical condition, they can help you decide whether you need emergency care or urgent care, and how and where to get that care)
- They can tell you what to do if you need care and your PCP's office is closed

You can reach one of these licensed health care professionals by calling Anthem Blue Cross at 1-800-224-0336. When you call, a trained support person may ask you questions to help determine how to direct your call.

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 to make sure you can have services in a language you understand.

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.



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Help in another language and for people with disabilities: How can I get help?

Protection for people with disabilities

The Americans with Disabilities Act (ADA) 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):

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 know. Your PCP will be able to help you or answer your questions.

At any time, you or your Member Representative can file a grievance (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 by L.A. Care. 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 "Complaints: What should I do if I am unhappy?" 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 by either your PCP, 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 will have grievance forms available in his or her office.
- Write, visit, fax or call Anthem Blue Cross.

Anthem Blue Cross
Grievance Coordinator
P.O. Box 9054
Oxnard CA 93031-0954
1-888-285-7801



Anthem Blue Cross Member Services Department
toll-free **1-888-285-7801**

L.A. Care Health Plan Member Services Department
toll-free **1-888-839-9909**

Complaints: What should I do if I am unhappy?

- You can also file a grievance online through the Anthem Blue Cross Web site at **anthem.com**. 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
1055 West 7th Street
Los Angeles, CA 90017
1-888-839-9909
1-213-438-5748 (fax)
- We can mail you a grievance form to fill out and send back to us.
- You can also file a grievance online through L.A. Care's Web site at www.lacare.org. Call L.A. Care to get a grievance form in another language or format (Braille, large print or other alternative formats).

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

For members with hearing or speech loss, you may call Anthem Blue Cross or L.A. Care's TTY telephone number for Member Services at 1-888-757-6034. You may call the TTY/TDD Statewide access number at 1-888-877-5379 (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.

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 California Department of Social Services (CDSS) 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.

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 by your health plan, you have the right to appeal, which means you can ask for a review of the decision. . You can also request a State Fair Hearing and file a grievance with the California Department of Managed Health Care (DMHC). Another option is to 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

Complaints: What should I do if I am unhappy?

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 California 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 an appeal

You may file an appeal in any of the ways used to file a grievance, including by telephone. Anthem Blue Cross will help you with interpreter services if you speak a language other than English. You may use the toll-free TTY/TDD numbers listed under “How to File a Grievance” if you are a non-hearing member. With your written consent, your doctor may also file an appeal on your behalf.

Within five (5) calendar days of getting your appeal, Anthem Blue Cross will send you a letter to let you know that we have your appeal and are working on it. Then, within 45 calendar days of getting your appeal, Anthem Blue Cross will send you a letter explaining how the appeal was resolved.

Filing an appeal or requesting a State Fair Hearing does **not** affect your medical benefits. If you file an appeal or request a Fair Hearing, you can continue to receive all covered benefits and services while the appeal is being resolved. To find out more about continuing all covered benefits and services, please call Anthem Blue Cross.

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 California Department of Managed Health Care (DMHC)” section of this handbook.



Anthem Blue Cross Member Services Department
toll-free **1-888-285-7801**

L.A. Care Health Plan Member Services Department
toll-free **1-888-839-9909**

Complaints: What should I do if I am unhappy?

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 by your Health Plan Partner, you can request a State Fair Hearing and file a grievance with the California 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 California 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 an appeal 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 appeal. You may file your appeal to Anthem Blue Cross either orally (via telephone or in person) or in writing. You can present evidence to support your appeal; however, the time available to present this evidence is limited to less than three (3) days. A decision will be made by Anthem Blue Cross within three (3) business days from the day your appeal was received.

You have the right to request an expedited State Fair Hearing. You can request an expedited State Fair Hearing and file an appeal with Anthem Blue Cross. For more information about State Fair Hearings, go to the "State Fair Hearing" section.

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

If you don't agree with the outcome of your appeal for urgent cases

If you prefer, 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 within 45 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 the DMHC, go to the "Contacting the Department of Managed Health Care (DMHC)" section. For information on how to request an IMR, go to the "Independent Medical Review" section.

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.

Complaints: What should I do if I am unhappy?

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 your Health Plan.

When to file an Independent Medical Review (IMR)

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



Anthem Blue Cross Member Services Department
toll-free **1-888-285-7801**

L.A. Care Health Plan Member Services Department
toll-free **1-888-839-9909**

Complaints: What should I do if I am unhappy?

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's grievance process before asking for an IMR of a decision to deny coverage on the basis that the treatment is experimental or investigational in nature.

Contacting the California Department of Managed Health Care (DMHC)

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.

Complaints: What should I do if I am unhappy?

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, <http://www.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 or appeal. 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 "Independent Medical Review" section to find out more.

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

You can ask for a State 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 (DPSS)
State Fair Hearings Section
P.O. Box 10280
Glendale, CA 91209



Anthem Blue Cross Member Services Department
toll-free **1-888-285-7801**

L.A. Care Health Plan Member Services Department
toll-free **1-888-839-9909**

Complaints: What should I do if I am unhappy?

Office of the Ombudsman

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

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.

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’s 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's Web site at www.anthem.com/ca or on L.A. Care's Web site at www.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 staff 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's 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 do 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



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L.A. Care Health Plan Member Services Department
toll-free **1-888-839-9909**

Confidentiality: What are my privacy rights?

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 a printed copy of the NOPP mailed to you, would like to pick up a paper copy of the NOPP, or would like to know more about the privacy, information security and confidentiality of your health information, please call 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 www.lacare.org, or by visiting Anthem Blue Cross online at www.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 California Department of Health Care Services (DHCS) at 1-916-255-5259, TTY at 1-877-735-2929, or the U.S. Office for 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 & abuse: How to identify it and report it

Fraud

Fraud includes, but is not limited to, intentionally using someone else's medical benefits for your health care services, intentionally using someone else's social security number to qualify for government assistance or intentional billing by 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 California 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 loan your social security card to anyone.
- Never sign a blank insurance claim form.
- Beware of anyone who offers you free medical services in exchange for your ID card. You should never give away your ID card to anyone in exchange for free medical services.
- If it sounds too good to be true, it probably is. Be careful about accepting medical services in addition to Medi-Cal when you are told they will be free of charge.



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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 any 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 current 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. This makes it easier for you to get the care you need. It is L.A. Care and Anthem Blue Cross's job to make sure you get the care you need. For example, if you need to see a specialist, it is your PCP's and our job to find a specialist who will see you.

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

This section explains why you are in managed care and the reasons why you can or 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.

Medi-Cal: How can I make sure I don't lose my coverage?

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:

- Some 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.



Anthem Blue Cross Member Services Department
toll-free **1-888-285-7801**

L.A. Care Health Plan Member Services Department
toll-free **1-888-839-9909**

Medi-Cal: How can I make sure I don't lose my coverage?

- 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 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 (RCAC)

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.



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More important information: What else do I need to know?

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

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

Write, visit or call Anthem Blue Cross
Anthem Blue Cross
P.O. Box 9054
Oxnard, CA 93031-9054
1-888-285-2801

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 1-888-285-2801 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.

If you have Medi-Cal and Medicare coverage

If you have both Medicare and Medi-Cal benefits, Medicare is your main coverage. You will still go to your Medicare doctors, specialists, hospitals and get most of your prescriptions from Medicare. L.A. Care will work with your Medicare doctor to provide you with Medi-Cal services you need.

This handbook explains your Medi-Cal benefits through L.A. Care. L.A. care will take care of your co-payments, medical services and supplies that are not covered by Medicare.

In order for L.A. Care to cover a service, the service must be:

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

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.

More important information: What else do I need to know?

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 California Department of Health Care Services (DHCS) will decide if the cost of the member’s medical care must be paid back. DHCS will never ask for more to be paid back than the value of the assets owned by the member at the time of his or her death.

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

California Department of Health Care Services (DHCS)
Estate Recovery Section, MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425
1-916-650-0490
1-916-650-6584 (fax)

Disruption in services

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).



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More important information: What else do I need to know?

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.

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

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 (DHCS) is the state agency that is responsible for the Medi-Cal program.

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

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

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

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

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



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Glossary of Terms

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 a Federally Qualified Health Center (FQHC), Los Angeles County clinic, community clinic, rural health clinic, Native American Health Clinic or other primary care facility.

Combined Evidence of Coverage and Disclosure Form is the L.A. Care/Anthem Blue Cross Member Handbook which has information about benefits, services and terms for members.

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

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

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

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

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

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

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

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

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

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

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

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

Glossary of Terms

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.



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Glossary of Terms

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

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

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

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

Involuntary/Involuntarily is when something is done without choice.

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

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

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

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

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

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

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

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

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

Member is a person who has joined a health plan.

Member Handbook, 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.

Glossary of Terms

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

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

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

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

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

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

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

Pediatric subacute services are the health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function

Pharmacy is a place to get prescribed drugs.

Phenylketonuria (PKU) is a rare disease. PKU can cause 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) is a doctor or clinic that takes care of a member's health care needs and works with the member to keep them healthy. The PCP will also make specialty referrals when medically necessary.

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



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Glossary of Terms

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
- Subacute facilities
- Home health agencies
- Pharmacies
- Laboratories
- X-ray facilities
- Durable medical equipment suppliers

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

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

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

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

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

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

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

- Psychiatric inpatient hospital services
- Targeted case management
- Psychiatric services
- Psychologist services
- Early, 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.

Subacute care is a level of care needed by a patient who does not require hospital acute care, but who requires more intensive skilled nursing care than is provided to the majority of patients in a skilled nursing facility. **Triage or screening** is the evaluation of a member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the member's need for care.

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

TTY/TDD is a communication device for the deaf, using a telephone system.

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

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

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	1-800-224-0336
L.A. Care Family Resource Center – Lynwood	1-888-525-9693
L.A. Care Family Resource Center – Inglewood	1-888-213-9374

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

Health Care Options:

Arabic	1-800-576-6881
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
Korean	1-800-576-6883
Laotian	1-800-430-4091
Mandarin	1-800-576-6885
Russian	1-800-430-7007
Spanish	1-800-430-3003

Important Phone Numbers

Tagalog	1-800-576-6890
Vietnamese	1-800-430-8008
TDD	1-800-430-7077
U.S. Office for Civil Rights	1-866-627-7748
	1-866-788-4989 (TTY)

Social Security Administration

Supplemental Security Income (SSI)	1-800-772-1213
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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 Program (WIC)	1-888-942-9675