

BCC SMALL GROUP MEMBERS - HMO

Members' Frequently Asked Questions About Blue Cross of California Small Group HMO Plans

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Customer Service

Q1. How do I get additional information about my plan or benefits?

A1. Connect to Customer Service via our interactive [Member Services](#) feature. The Member Service pages link you to the details of your health care plan, including dependent information and claim status. They also serve to electronically connect you to Customer Service for ID Card replacement or benefit issues. You must receive a personal identification number (PIN) to safeguard your personal information before you can access Member Services. You can request a PIN number on-line at the Member Services page, or by calling the toll free Customer Service number printed on the back of your ID Card and a dedicated customer service associate will assist you. Customer Service is available from Monday through Friday, 8:30 AM to 12 midnight, (PST) Pacific time. You will also find detailed information about your plan or benefits by reviewing your Evidence of Coverage. If you have any questions

Monday through Friday	5:00am-10:00pm (PST)
Saturday and Sunday	6:00am-3:00pm (PST)

Q5. How do I get a provider directory?

A5. You can get a directory of Blue Cross HMO (CaliforniaCare) providers as follows:

- If you are already a member, your renewal kit includes a brochure with instructions for finding a Blue Cross HMO provider using our Internet web site to link to [Provider Finder](#) . The renewal kit also includes a postcard for you to mail to us if you would rather get a copy of the directory.
- You can also call our toll free Customer Service number shown on your Member ID Card and ask us to send you a directory. Customer Service is available from Monday through Friday, 8:30 AM to 12 midnight, (PST).
- If you are a new member, a directory request postcard is included in your enrollment kit.
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Q6. How do I get a list of preferred drugs (formulary information)?

A6. If you have questions about whether a drug is on the prescription drug formulary or needs to be approved, please [click here](#) or call us at (800) 700-2533.

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Enrollment

Q7. How can I cover my newborn from birth?

A7. Newborns are covered for the first 30 days of life.

Requests for enrollment of newborn children must be made within the first 30 days of life. You must submit a request in writing. The request should include your certificate number, the newborn's complete name, date of birth and sex. Blue Cross of California must receive this form within 30 days from the date of birth. If Blue Cross receives this request on the day following the 30th day of life, an Individual Enrollment Application must be completed and sent to Blue Cross. The application is subject to Underwriting. Once added, your newborn coverage will be billed retroactive to their birth date.

Q8. How do I obtain coverage for my newly adopted child?

A8. A child being adopted by the Subscriber will have coverage up to thirty (30) days from the date on which the adoptive Child's birth parent or appropriate legal authority signs a written document granting the Subscriber or the enrolled Spouse the right to control health care for the adoptive Child, or absent this document, the date on which other evidence exists of this right.

To continue coverage, the adopted child MUST be enrolled as a family member by notifying us in writing within sixty (60) days of the date the Subscriber's authority to control the Child's health care is granted and the Subscriber will be responsible for any additional subscription charges due effective from the date the Subscriber's authority to control the Child's health care is granted.

Q9. How do I add or delete family members?

A9. To add Family Members:

Spouse:

You will be required to submit a completed application for the spouse that references the enrolled Subscriber's Certificate Number. The spouse is subject to underwriting.

Newborn Child:

For coverage to continue beyond the automatic thirty (30) days from the date of birth to an already enrolled Subscriber or Spouse, Blue Cross must receive within 60 days of the Child's birth, an application to enroll the Child and any additional charges due.

Adopted Child:

Blue Cross must receive an application to enroll the Child within 60 days of acquiring the Child in order for coverage to continue beyond the first thirty (30) days from the date of adoption. Any additional charges can apply and are due.

Children under 19 that are not newborns or newly adopted:

You will be required to submit a completed application for that(those) child(ren) that references the enrolled Subscriber's Certificate Number. Each child is subject to underwriting.

To Delete Family Members:

Blue Cross must receive a request to delete family members in writing. The request will become effective the first of the month following the request.

Q10. Can I cover a dependent who lives out-of-state or my child away at school?

A10. Your dependents that live out-of-state or are away at school are covered for emergency services only under a Blue Cross HMO plan.

Q11. How often can I change benefit plans?

A11. You may only change benefit plans during your company's open enrollment period, unless you have a change in family status either through marriage, or the birth or adoption of a child. Changes in family status allow persons to enroll who were not previously enrolled.

Q12. How long can my children remain covered?

A12. Qualified children can be covered from their nineteenth (19th) to the twenty-fourth (24th) birthday as long as they qualify as dependents for federal income tax purposes and are full-time students (for twelve (12) or more credits) and attending an accredited college, university, vocational or technical school. Blue Cross requires written proof of student status annually

Q13. How long can my child be covered if he or she has disabilities?

A13. If your child reaches, on the first of the month, the limiting age (19 years, 23 years if in college), and is at least one-half dependent on the Subscriber for support and is incapable of self-sustaining support due to mental retardation or physical handicap they may remain on the policy. We must receive written proof of such handicap and dependency within thirty-one (31) days of the child reaching limiting age and as often as we may require thereafter. Please see your Combined Evidence of Coverage/Certificate for more details.

Q14. Can I choose a different Primary Care Physician (PCP) than my spouse?

A14. Every member of your family can choose a different Medical Group, Individual Practice Association (IPA), or PCP within that Medical Group or IPA.

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ID Cards

Q15. How do I order additional ID Cards?

A15.

There are two simple methods in which to order ID cards.

- Order ID cards on this web site by clicking on the [Member Services](#) link.
- Call our customer service department toll-free at (800) 627-8797

Q16. Do I need to carry my ID Card with me at all times?

A16. Yes, we recommend that you carry your ID Card at all times. You may need it in case of an emergency. You may be required to present your ID Card at your doctor's office or at a hospital.

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Physicians and Other Providers

Q17. How do I find a network provider?

A17. You have three options:

1. Go to our [Provider Finder](#) and follow the prompts to retrieve your health plan's network providers. For directions, simply click on the provider's name and you are linked to an area map that shows various routes to the provider's location.
2. Look in the printed Blue Cross HMO Directory. You can get a provider directory mailed to you by calling Customer Service at the toll-free number on your ID card.
3. Call the toll-free Customer Service number on your ID Card.

Q18. What is a Primary Care Physician (PCP)?

A18. A Primary Care Physician is a doctor who is a member of the medical group you have chosen to provide you and your family's health care. Primary Care Physicians include general and family practitioners, internists and pediatricians.

Q19. What are the advantages of using network providers?

A19. Under the HMO plan, you are only covered for services through the medical group and from the provider that is designated as your Primary Care Physician.

Contact your Primary Care Physician before seeing any other physician that is not in your physician's medical group/office or contact our customer service department at the number listed on your ID card, except in a medical emergency.

Q20. What happens if my current physician is not a network provider?

A20. Call our Customer Service number on your ID Card to get a network assigned Primary Care Physician.

Q21. How do I change my Primary Care Physician (PCP)?

A21. If you are an HMO Plan Member, you should contact the Customer Service Department to request a change to your Primary Care Physician.

Q22.Can I change my Primary Care Physician (PCP) any time I want?

A22.There are three ways you can change your medical group/PCP:

- At your company's next open enrollment period, you may choose any medical group within the enrollment area, in which you live or work.
- If you change your permanent residence or employment location and your new residence or employment location is not within the enrollment area of your current medical group, you must request a transfer to another medical group by calling the Customer Service number on your ID Card or by filing a Membership Change form within 31 days of your move. You may request a Membership Change form by calling Customer Service or [click here](#).
- Under special circumstances, you can request a transfer by calling the Customer Service number on your ID Card or by filing a Membership Change form. You must include the reasons for your request. We must approve your request for the transfer to become effective.

Q23.What if a Primary Care Physician cannot see me right away?

A23. If your independently contracted Primary Care Physician (PCP) cannot see you right away ask the PCP if he/she has a partner or covering physician who can see you right away. You may also contact customer service at the toll-free number listed on your ID card.

Q24. What if a network provider isn't available to treat my condition?

A24. Your primary care doctor is the first doctor you see for all your health care needs. He/ she may refer you to another doctor if you need special care.

The following is the criteria if you require medical treatment of a specialist who is a Non-Participating Physician or require special services that must be provided at a Non-Participating Hospital.

- There is no Participating Physician who practices in the appropriate specialty or there is no Participating Hospital or Participating Ambulatory Surgical Center which provides the required services or has the necessary facilities within a thirty (30) mile radius of the principal residential address as reflected on our files or within the county in which the principal residence is located whichever is less, and
- The Member is referred to the Non-Participating Provider by a Participating Provider, and
- Blue Cross has authorized the referral before services are rendered.

Q25. Can I go to a non-network provider?

A25. Under the HMO plan, you are only covered for services provided by your Primary Care Physician, except in an emergency. If you need emergency medical treatment, please contact your medical group for instructions. If you go to a non-network provider, you may be responsible for all medical costs associated with that course of treatment.

Q26. Do I need a referral to see my OB-GYN?

A26. No. You can get OB-GYN services from a doctor who specializes in caring for women (OB-GYN) or family practice doctor who does OB-GYN **and** works with your medical group. You can self-refer to a participating provider for these services without an OK from your primary doctor. Ask your HMO coordinator for the list of OB-GYN health care providers you must choose from.

Q27. Can I self refer to any provider for my Well Woman exam (PAP/mammogram)?

A27. Under our Well Woman benefit, women may visit an OB-GYN within their medical group/IPA without a referral or authorization from their primary care physician for these services.

Q28. What if my PMG/IPA does not have a particular specialist I need to see within its network?

A28. Your Primary Care Physician will refer you to a Blue Cross HMO contracting specialist, which is associated with your medical group. Your medical group is required to assure that you have access to the types of specialists you need.

Q29. What if my Primary Care Physician (PCP) or Medical Group leaves the Blue Cross HMO network?

A29. Sometimes your PCP or Medical Group will no longer be affiliated with the Blue Cross HMO network. In an effort to make this transition as smooth as possible, Blue Cross will reassign you to another medical group. Your enrollment with the Blue Cross HMO will not otherwise be affected in any way. A new ID Card reflecting this change will be mailed to you. If you prefer to make a different selection, please contact a Dedicated Customer Service Associate at the number listed on your ID Card.

Transition Assistance Program

The goal of the Transition Assistance Program is to facilitate the continuity of care for a new CaliforniaCare member who is covered under a group contract if the member is receiving services during a current episode of care for an acute condition from a non-participating provider.

If a new member is receiving services during a current episode of care for an acute condition from a non-participating provider, the member may apply to CaliforniaCare's Medical Case Management Department for transition assistance under this program. The Medical Case Management Department will evaluate the member's application and may request medical records from the member or the member's non-participating provider.

In providing transition assistance under this program, CaliforniaCare shall not be required to cover services or provide benefits that are not otherwise covered under the terms and conditions of the member's group contract.

If a treating physician leaves your medical group while you are in a course of treatment, your PMG provides transitional assistance for continuity of care.

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Approvals and Referrals

Q30. What services require prior approval or referral?

A30. Members must obtain referrals from their Primary Care Physicians (PCP). Referrals are made when the PCP and the Medical Group deem services of a specialist medically appropriate. The PCP arranges for the referral and gives the member a completed referral form that authorizes specific treatment or services.

Q31. How do I get prior approval or referral?

A31. Your Primary Care Physician (PCP) may refer you to another doctor if you need special care. Your PCP must approve all services except when you have an emergency. Your PCP's Medical Group has to agree that the service or care you will be getting from the other health care provider is medically necessary. Otherwise it won't be covered.

- You will need to make the appointment at the other doctor's office.
- Your primary care doctor will give you a referral form to take with you to your appointment. This form gives you the OK to get this care. If you don't get this form, ask for it or talk to your Blue Cross HMO coordinator at the doctor's office.

Remember: Payment will only be made for the number of visits and the medical care that is specifically authorized by your PCP. Before obtaining any other care, be sure to check with your PCP to make sure that additional care will be authorized. You are responsible to pay for services rendered that are not authorized by your PCP.

Q32. What if I don't get prior approval or referral?

A32. Your Primary Care Physician (PCP) must approve all the care you get except when you have an emergency. Your PCP's medical group has to agree that the service or care you will be getting from the other health care provider is medically necessary. Otherwise it won't be covered. Your plan pays for the number of visits and the type of special care that your PCP approves.

Specialist Standing Referrals

If the PCP, specialist, and medical director together decide that continuing care from a specialist is needed, you may receive an authorization for a standing referral based on an agreed upon treatment plan, if any.

After receiving standing referral approval, the specialist is authorized to perform health care services.

Second Opinion

Your medical group is responsible for arranging second opinions and specialty care with health care providers who are part of or who are affiliated with your Blue Cross HMO medical group. If your Primary Care Physician (PCP) referred you to a specialist and you want a second opinion, you have the right to a second opinion by an appropriately qualified health care professional that is part of the Blue Cross HMO provider network. To ask for a second opinion about recommendations by your PCP, call your PCP or your Blue Cross HMO coordinator at your medical group. To ask for a second opinion from a specialist outside your medical group, please call the Customer Service number on your ID Card.

Q33. When do I need a referral from my physician?

A33. If you need specialty care, which cannot be provided by your Primary Care Physician (PCP) at your Medical Group, your PCP will arrange to send you to a specialist (within your Medical Group whenever possible) or to a facility outside of your Medical Group.

Female Blue Cross HMO members may self-refer to an OB/GYN within their Participating Medical Group (PMG) or Independent Physicians Association (IPA) without first obtaining a referral from their PCP.

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Emergency Care

Q34. What do I do in case of an emergency?

A34. When faced with a medical emergency, always seek immediate care by going directly to the nearest emergency room, calling 911, or contact a physician. Review your Evidence of Coverage for more details.

Note: You or a family member must notify your medical group/IPA within 48 hours of the initiation of treatment (or as soon as your medical condition permits). Review your Evidence of Coverage for more details.

Q35. Do you cover emergency care?

A35. Yes. An Emergency is defined as a sudden, serious, and unexpected illness, injury, or health problem (including sudden and unexpected severe pain). This includes any illness, injury or problem (including psychiatric conditions) you reasonably believe could endanger your health if you don't get medical care right away. Some examples of an emergency condition are:

- Severe shortness of breath
- Uncontrolled or severe bleeding
- Loss of consciousness
- Suspected heart attack or heart attack
- Fractures
- Poisoning
- Severe burns

Q36. What is Urgent Care?

A36. Urgent care is defined as a service you receive for a sudden, serious, or unexpected illness, injury or condition. Although not an emergency condition, care is needed right away to relieve pain, find out what's wrong, or treat the problem.

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Travel Coverage

Q37. What do I do if I need care while traveling?

A37. You can seek medical treatment at an urgent care facility if you are more than 20 miles away from your medical group. You or a family member must contact Blue Cross of California within 48 hours of the initiation of treatment.

Within California

For urgent care, if care can't wait until you get back to make an appointment with your primary care physician, get the medical care you need right away. You must call us within 48 hours if you are admitted to a hospital.

Q38. What routine coverage do I have while I am traveling?

A38. Routine care is not covered while traveling.

Q39. What emergency coverage do I have while I am traveling?

A39. Call 911 or seek immediate treatment at the nearest facility. If you are admitted to a hospital, you or a family member must call us within 48 hours. Review your Evidence of Coverage booklet for more details.

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Pharmacy

Q40. How do I get prescriptions filled through a mail order pharmacy?

A40. First time mail order customers should ask their doctor for a written prescription for a 30 or 60 day supply (as defined by your plan), plus refills when appropriate. To secure a mail order form online, [click here](#) or call Customer Service at the number on your ID card. Fill out a mail order form and return it along with your prescription and any necessary copayment to PrecisionRx at P.O. Box 961025, Fort Worth, Texas, 76161-9863. The toll-free number is (866) 274-6825. You may order refills via the Web site at precisionrx.com. The delivery of your prescriptions will take 10-14 days.

Q41. What is the difference between generic and brand-name drugs and how does that difference affect my benefits?

A41. Brand name drugs are those drugs that are marketed under a specific trade name by a pharmaceutical manufacturer. In most cases, these drugs are still under patent protection, meaning the manufacturer holding the patent is the sole source for the product. Once the patent expires, other manufacturers may make the same drug in generic form. Generic drugs are safe, effective and equivalent to brand name medications that may cost considerably less than the brand name medications. Generic drugs must meet the same high standards of quality as brand name drugs and are formulated to have the same effect in the body as the brand name version. Generic drugs often become available when a brand name drug's patent expires.

For you, this means, whenever possible, you should ask for the generic drug to treat your condition because the generic drugs will cost you less.

Q42. Can I get reimbursed for prescriptions I purchased from a pharmacy outside the network?

A42. Yes, however, it will cost you more if you go to a non-participating pharmacy. Take a claim form with you to the non-participating pharmacy. If you need a claim form or if you have questions, visit our web site at www.bluecrossca.com or call (800) 700-2541. Have the pharmacist fill out the form and sign it. Then send the claim form (within 15 months) to:
Blue Cross Prescription Drug Program
P.O. Box. 4165
Woodland Hills, CA 91365-4165

Q43. If I am going to be out of town for an extended time, how do I get an extra supply of drugs to cover me through that period?

A43. If you are out of state and you need medicine, call (800) 700-2541 to find out where there is a participating pharmacy. If there is no participating pharmacy, please call the toll-free pharmacy customer service number listed on your ID card.

Q44. What is a drug formulary (or preferred drug list) and how does it affect me?

A44. A prescription drug formulary is a list of prescription drugs, identified by the pharmacy, which are therapeutically appropriate and cost-effective. For a list of medications in this program, [click here](#). For a Prior Authorization form, [click here](#). You may also call (800) 700-2533.

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Claims

Q45. How do I file a claim?

A45. Usually there is no need to submit a claim. The only services for which you need to submit a claim are authorized: inpatient care; emergency services; and outpatient prescription drugs purchased from a non-participating pharmacy under the Prescription Drug Program.

Should it become necessary to file a claim, you can get a claim form by downloading the claim [Forms](#) from our Web site or by calling Customer Service number on your ID card. Send us a copy of the claim with your certificate number attached. Be sure to use a separate claim form for each patient and each provider.

Q46. How long do I have to file a claim?

A46. Fifteen (15) months from the date of service. We are not liable for the benefits of the plan if claims are not filed within this time period.

Q47. A provider has billed me, how do I know how much of the bill to pay?

A47. Your HMO provider will bill us directly. Should you receive a bill, do not ignore it. Please call us at the number on your ID card. Immediately send a copy of the bill to your PCP or medical group, then call the service provider and tell them you forwarded the bill to your PCP or medical group.

Q48. How can I check the status of my claim?

A48. Connect to Customer Service via our interactive [Member Services](#) feature. The Member Services pages link you to the details of your health care plan, including dependent information and claim status. They also serve to electronically connect you to Customer Service for ID Card replacement or benefit issues. You must receive a personal identification number (PIN) to safeguard your personal information before you can access Member Services. You can request a PIN number on-line at the Member Services page, or by calling the toll free Customer Service number printed on the back of your ID Card and the Customer Service Representatives will assist you.

Q49. What are co-payments?

A49. Co-payment is the member's share of the cost of a unit of service or unit of time. This is sometimes a percentage of the charges but may also be a dollar amount for specified services.

Q50. What is the difference between deductibles and co-payments?

A50. Co-payment is a type of member cost sharing that requires a flat amount per unit of service or unit of time. This may be a percentage of the charges or a dollar amount for specified services. Deductible is an amount the insured person must pay before benefit payments for covered services begin. The deductible is usually a set amount or a percentage determined by the member's contract. For example, a plan might require the insured to pay the first \$500 of covered expenses during a calendar year before any benefits are payable.

Q51. How does my out-of-pocket maximum work?

A51. Out-of-pocket maximum refers to the most you pay for covered expenses during the year before the plan begins paying 100% of covered expenses for the remainder of the year. It is a sum of deductible and coinsurance amounts. Only covered expenses count toward the maximum. Other costs, such as amounts you pay for non-covered services or charges in excess of our allowances, don't count.

Q52. How does my co-pay limit work?

A52. Co-pay limit is the most you will have to pay in one calendar year in co-pays. Once you reach your co-pay limit, no additional co-pays will be required. You must save your receipts and let us know when your co-pay limit is reached.

Q53. What is Coordination of Benefits (COB)?

A53. Coordination of Benefits (COB) is a provision to coordinate 100% of covered charges between multiple group health insurance and to designate the order in which the multiple carriers are to pay benefits. Under a COB provision, one Plan is determined to be primary and its benefits are applied to the claim. Part or all of the unpaid balance is usually paid by the secondary Plan to the limit of its liability. The coordination provisions apply separately to each member, per calendar year, and are largely determined by California law.

Q54. Why did I receive a Coordination of Benefit Questionnaire and do I have to return it?

A54. Yes. The Coordination of Benefit questionnaire is used to determine if you are covered by more than one group health insurance carrier. Please fill it out and return to us so that we may process your claims correctly.

Q55. What do I do with my foreign medical bill for care I received outside of the USA?

A55. The member should ask for the claim to be written in English and:

- Submit the itemized bill and medical records (in English) with the policyholder's identification number clearly displayed. A claim form may also be submitted with the itemized bill if it is available, but it is not required.

- Use a separate form for each enrolled family member and each provider of service.
- Submit the form to the Customer Service address printed on the member's ID Card.
- Blue Cross does not pay benefits in the local currency of the claims submission site. The claims amounts are converted into U.S. dollars. You are responsible for any costs incurred to translate the bill or records into English.

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Grievances & Appeals

Q56. What is the procedure for lodging a complaint against a provider?

A56. Request an appointment with your Blue Cross HMO coordinator at your medical group or IPA first. He or she may be able to help you right away. You may also call the toll free Customer Service number listed on your ID Card.

If you are still not satisfied and wish to file a complaint, you should fill out a Member Issue Form. This form is available from your Blue Cross HMO coordinator or from us.

Q57. How do I appeal a disputed health care service pertaining to medical necessity or appropriateness of service?

A57. You may ask for a review from Blue Cross of California. Call us at the Customer Service number shown on your Member ID Card or write to us at the following address:

Blue Cross of California
Grievance and Appeal Management
P.O. Box 4310
Woodland Hills, CA 91367

Tell us about your complaint and enclose any bills or records. Your issue may then become part of our formal grievance process and your issue will be resolved within 30 days, or 3 days if your case involves an imminent threat to your health and should be expedited.

Q58. How do I appeal a claim payment or denial? If I am dissatisfied with the resolution through the formal grievance process, what are

my remaining options?A58. The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the Customer Service number on your ID card 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 Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The department also has a toll-free number (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 applications forms and instructions online.

In addition, you may at any time pursue other dispute remedies, which may include Small Claims Court or Binding Arbitration.

Binding Arbitration:

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to, this Agreement, or breach or rescission thereof, or in relation to care or delivery of care, including an claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The member and Blue Cross agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by court or jury.

Please send all Binding Arbitration demands in writing to:

Blue Cross of California
P.O. Box 9086
Oxnard, CA 93031-9086

Please see your Evidence of Coverage or call Customer Service for more information.

ERISA:

If your claim has been denied, in whole or in part, and your group health plan is subject to the Employee Retirement Income Security Act, 29 U.S.C. 1001, Et. Seq., ("ERISA") you may be entitled to additional rights. Please consult with your plan administrator to determine if your plan is governed by ERISA.

If your plan is governed by ERISA, you may have the right to bring a civil action under ERISA Section 502(a)(I)(B). This right can be exercised when all required reviews of your claims, including the appeal process, have been completed, your claim was not approved, in whole or in part, and you disagree with the outcome of the resolution.

Under ERISA, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits.

Once you have completed all mandatory appeals, you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Q59. What if waiting for you to decide on my appeal would harm my health?

A59. If your case involves a sudden threat to your health, such as the loss of life or limb or major bodily function, we'll expedite the review and resolve your complaint within three (3) days.

Q60. My Explanation of Benefits says I received services that I did not have. What should I do?

A60. Please call the Customer Service number on the back of your ID Card for assistance.

Q61. If I feel I need a second opinion, how do I go about obtaining one?

A61. Your medical group is responsible for arranging second opinions and specialty care with health care providers who are part of or who are affiliated with your Blue Cross HMO medical group. If your Primary Care Physician (PCP) referred you to a specialist and you want a second opinion, you have the right to a second opinion by an appropriately qualified health care professional that is part of the Blue Cross HMO provider network. To ask for a

second opinion about recommendations by your PCP, call your PCP or your Blue Cross HMO coordinator at your medical group. To ask for a second opinion from a specialist outside your medical group, please call the Customer Service number on your ID Card.

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General Information

Q62. How do my HMO benefits work?

A62. When you enroll, you should choose a Primary Care Physician (PCP). Your PCP will be the first doctor you see for all your health care needs. If you need special care, this doctor will refer you to other health care providers or specialists. Your PCP will be part of a Blue Cross of California HMO contracting medical group.

Q63. What happens to my coverage if I move out of the area?

A63. Please call the Customer Service number on your ID Card and request that your file be updated with your new address.

When you move your residence more than thirty (30) miles from your current Medical Group, please notify Blue Cross in writing and request a transfer to another Medical Group that is located within 30 miles of your new residence. Blue Cross must be notified within thirty (30) days in order to make the appropriate arrangements.

If you move your residence to a location that is outside of the HMO licensed service area, you may be required to change your plan selection.

Q64. What happens to my coverage if I quit my job or I'm laid off or fired?

A64. When your job ends, usually for any reason other than gross misconduct, you can pay to continue, for a limited time, exactly the same benefits you have while employed, through a federal law called COBRA. Your employer must provide you with detailed information regarding the terms, cost and duration of COBRA benefits upon termination of your employment.

Note: If you are offered COBRA and fail to take it, you will lose future rights provided by Federal Law to certain guaranteed individual coverage.

Q65. What happens to my coverage if I turn 65?

A65. Members eligible for Medicare will receive the full benefits of this plan except those who are receiving treatment for end-stage renal disease or those who are entitled to Medicare benefits as disabled persons. Please see your Evidence of Coverage booklet for more details.

Q66. What happens to my coverage if I retire?

A66. You may be able to continue your coverage for a limited time. See answer number 64 above. Ask your employer for more information. Your employer will let you know that you have a right to keep your health plan under COBRA. You should know that you might have to pay the whole cost of staying on the health plan.

Q67. What if I become disabled?

A67. If you are a totally disabled subscriber and under the treatment of a physician on the date of discontinuance of your Blue Cross coverage, your benefits may be continued for treatment of the totally disabling condition. Please refer to your combined Evidence of Coverage and Disclosure Form/Certificate for more details.

Q68. What if my spouse and I divorce?

A68. Your family members can continue coverage for a limited time, through COBRA, if you are divorced or legally separated. Ask your employer for more information.

Q69. Is my child covered while in college?

A69. You and your family members do not have to enroll in the same medical group. For your college age student (from 19 to 23 years old), you may choose a medical group close to the college. You can cover your enrolled dependents, including students and family members, who temporarily live outside of California through Guest Membership. Guest Membership offers temporary HMO services from a "host" Blue Cross Blue Shield affiliated HMO. To qualify, you or your enrolled family members, must live outside California for 90-180 consecutive days. Ask your benefits administrator or your Human Resources Department representative for a Guest Membership application, or call Blue Cross Customer Service.

Q70. Do I have coverage for pre-existing conditions?

A70. All pre-existing conditions are covered under our HMO plan.

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