BCC MEMBERS PPO - SMALL GROUP

Members' Frequently Asked Questions About Blue Cross of California and BC Life & Health Insurance Company Small Group PPO Plans

Click on a section below to view applicable questions or scroll down to view all Questions:

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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 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 Combined Evidence of Coverage booklet. If you should have

any questions please contact a dedicated customer service associate or speak with your Group Administrator.

Q2. How and when can I contact the health plan?

A2. Whenever you have a question about your plan, you can either contact us through online member services or you may call a dedicated customer service representative at the toll-free number on your ID card. The Member Service pages link you to:

- The details of your health care plan, including dependent information and claim status, and
- Customer Service for ID Card replacement or benefit issues electronically.

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 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.

Q3. How do I change my name or address?

A3. Please call the toll free Customer Service number on your ID Card and request that your file be updated with your new name and address. Written verification by mail or fax will be required.

You may also submit your name and/or address change in writing to:

Blue Cross of California*
P.O. Box 9062
Oxnard CA 93031-9062

* Blue Cross of California also provides various administrative services for BC Life & Health.

Q4. What are your customer service hours?

A4. The following are our customer service hours:

Medical Plans

Monday through Friday	8:30-midnight (PST)
Saturday and Sunday	Closed

Pharmacy Plans

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 PPO (Prudent Buyer) providers as follows:

- If you are already a member, your renewal kit includes a brochure with instructions for finding a Blue Cross PPO 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.
- If you are a new member, a directory request postcard is included in your enrollment kit.

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 is away at school?

A10. Dependents that live outside of California for more than six (6) consecutive months should apply for coverage in the state of residence. If you require medical attention outside of California, please refer to www.bluecares.com to locate a Blue Cross/Blue Shield provider in that area. You can also obtain a provider outside of California by calling toll-free 1-800-810-BLUE.

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.

EPO Members Note: Our EPO plan only covers out-of-state emergencies.

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 for more details.

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ID Cards

Q14. How do I order additional ID Cards?

A14.

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

Q15. Do I need to carry my ID Card with me at all times?

A15. 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.

Q16. Why hasn't my child been issued an ID Card with his/her name?

A16. Currently, ID cards are issued in the name of the Subscriber only. If you have any questions regarding this policy, please feel free to contact the customer service number listed on the ID card.

Q17. My child lives with his/her other parent, but is insured under my policy. Can I get an ID Card issued with his/her name?

A17. Currently, ID cards are issued in the name of the Subscriber only. If you have any questions regarding this policy, please feel free to contact the customer service number listed on the ID card.

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Physicians and Other Providers

Q18. How do I find a network provider?

A18. You have two 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 PPO 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.

Q19. What are the advantages of using network providers?

A19. Receiving services from Blue Cross PPO Providers can substantially reduce your out-of-pocket costs. These lower costs are due to negotiated rates that Blue Cross PPO providers have agreed to accept. You do not need to make payment for services, unless your plan has an office visit copayment, when you receive care from Blue Cross PPO providers. Blue Cross PPO providers file claims to Blue Cross for our members, then bill you for remaining portion of their charges.

Note: If you have not satisfied your annual deductible at the time you visit a provider, that provider can require you to pay your deductible at the time of service.

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 physician that is part of our network. If you utilize a Non-Participating Provider, your out-of-pocket expenses will be considerably higher than when you use a Participating Provider. You will be responsible for all charges in excess of what Blue Cross allows for that provider.

Q21. May I go to a non-network provider?

A21. You may utilize a non-network provider, however your out-of-pocket expenses will be higher than if you utilized a Participating Provider. In some cases, Non-Participating Providers are not covered unless for the initial

treatment of a medical emergency. Please consult your Combined Evidence of Coverage.

EPO Members Note: Our EPO plan only covers Non-Participating Providers in an emergency.

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Approvals and Referrals

Q22.What services require prior authorization?

A22. All inpatient Hospital admissions (except for the delivery of a Child, Substance Abuse or mastectomy surgery), Facility Based Treatment for Mental or Nervous Disorders, Skilled Nursing Facility admissions, Infusion Therapy (in any setting), and Home Health Care. There is an additional copayment per admission, treatment or course of treatment if this prior authorization (or Preservice Review) is not obtained.

Q23. How do I get prior authorization?

A23. Instruct your physician to request prior authorization (or preservice review) at least three (3) working days before a scheduled service or call the toll-free Blue Cross of California Review Center at 800-274-7767.

Q24. What if I don't get prior authorization?

A24. You are always responsible for initiating prior authorization (or preservice review). Whenever preservice review has not been performed for an admission to a Hospital (except for the delivery of a child, mental or nervous disorders and substance abuse, or mastectomy surgery), skilled nursing facility, or infusion therapy (in any setting), depending on your coverage you may be required to pay an additional copayment for that admission or therapy. This copayment is in addition to any other copayment required by this agreement and will NOT apply toward your yearly deductible or maximum copayment/coinsurance limit.

Q25. When do I need a referral from my physician?

A25. A referral is not required if you select a specialist that participates in the Blue Cross of California Network.

Please note: If you select a specialist that does not participate in the network, your out-of-pocket costs will be considerably higher than when you

use Participating Providers. You will be responsible for any amounts in excess of what we allow in benefits for Non-Participating Providers. Please consult your Combined Evidence of Coverage for more information.

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Emergency Care

Q26. What do I do in case of an emergency?

A26. When faced with a medical emergency, always seek immediate care by going directly to the nearest emergency room, calling 911, or contact a physician.

Q27. Do you cover emergency care?

A27. 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

Q28. What is Urgent Care?

A28. 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.

If you need to consult with a nurse to assess a medical condition, then call a MedCall nurse at the number on your ID card. MedCall is available 24 hours a day, 7 days a week.

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Travel Coverage

Q29. What do I do if I need care while traveling outside of California or out of the country?

A29.

Outside of California
The convenience and savings of your Blue Cross PPO coverage goes with you when you're traveling nationwide or worldwide with the BlueCard, a national network of Blue Cross/Blue Shield plans. If you are traveling outside California, and need medical attention please call 1-800-810-BLUE. The BlueCard Access Call Center will help you find a physician and/or hospital in your area.. You may also access the information through www.bluecares.com, the Blue Cross Blue Shield Association's Web site. Simply click on the Blue Card Doctor & Hospital hotlink and complete the requested information to locate a PPO provider as close as five miles from your location.

Out of the Country
If you need care while traveling out of the country, the BlueCard Worldwide program covers inpatient and emergency care services from many international providers. To access benefits, simply present your Blue Cross member ID Card when you receive services from a participating provider. BlueCard Worldwide providers will not require a payment from you at the time of your treatment and they will bill us directly for their services. For updated information on international network providers, visit their Web site at http://www.bluecares.com/healthtravel/finder.html. You can also get information on Worldwide providers by calling BlueCard Provider Access toll-free at 1-800-810-BLUE. Coverage for services from international providers may be limited. For complete information, please refer to your Evidence of Coverage and Disclosure Form.

If you are unable to access a participating international provider and you require care for an emergency condition or injury, go to the nearest provider and get treated. Please notify Blue Cross of California as soon as possible if you are admitted into a hospital. Ask for your claims and medical records to be provided to you in English, and mail them to us for processing.

Q30. What routine coverage do I have while I am traveling?

A30. Please refer to your Combined Evidence of Coverage or contact us at the customer service number listed on your ID card.

Q31. What emergency coverage do I have while I am traveling?

A31. It is to your benefit to visit a Participating Provider to save money even when you are traveling. If you are traveling in the state of California and need emergency care, you will be charged 25% of customary and reasonable charges or billed charges, whichever is less PLUS all charges in excess of customary and reasonable. If you are traveling outside of California and need to see a doctor, you will be charged 25% of the BlueCard Provider's Negotiated Price.

In an emergency, you should call 911 or seek immediate treatment at the nearest facility. If admitted to the hospital directly from the emergency room, you will not be charged the emergency room deductible. Also, if you are admitted to a hospital, you or a family member should call the Customer Service number on your ID card as soon as your medical condition permits. The hospital and Blue Cross will work together to coordinate your care.

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Pharmacy

Q32. How do I get prescriptions filled through a mail order pharmacy?

A32. First time mail order customers should ask their doctor for a written prescription for a 60 day supply (as defined by your plan), with up to five (5) refills when appropriate.

Obtain a mail service prescription drug form by calling Customer Service at the toll-free number listed on your ID card. You can also get the form on our web site by clicking **here**.

Complete the mail order form. Return it along with your prescription and any necessary copayment (per 30 day supply) to:

Precision RX
PO Box 961025
Fort Worth, TX 76161-9863
(866) 274-6825

You may order refills via the website at: www.precisionrx.com. You will receive your refill within 10-14 days.

Q33. What is the difference between generic and brand name drugs and how does that difference affect my benefits?

A33. 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.

Q34. Can I get reimbursed for prescriptions I purchased from a pharmacy not in the network?

A34. 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, call (800) 700-2533 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

Q35. 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?

A35. If you are going on vacation and will not be able to obtain your next supply of medication, you should call (800) 700- 2533.

Q36. What is a drug formulary (or preferred drug list) and how does that affect me?

A36. A prescription drug formulary is used to help your doctor make prescribing decisions. This list of drugs is updated quarterly by a committee of doctors and pharmacists so that the list includes drugs that are safe and effective in the treatment of disease. The goal of the formulary list of prescription drugs, as established for the Pharmacy Plan, is to identify and

promote prescription drugs, 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

Q37. How do I file a claim?

A37. You do not have to file a claim form for services rendered by Blue Cross PPO providers. Blue Cross PPO providers file claims directly to Blue Cross for services rendered. The physician will bill you for the remaining portion of their charges for which you are responsible. If you receive services from Non-Participating Providers, you may need to submit a member claim form directly to Blue Cross of California. You can get a claim form from your employer, by downloading the claim forms from our Web site by clicking **here**, or by calling the Customer Service number on your ID Card. Be sure to use a separate claim form for each patient and each provider.

When filing a claim form, please submit the claim form and the bill from the provider of service. This bill must include the following:

- Name of Patient
- Date or dates of service
- Procedure codes
- Charge for each procedure
- Providers name, address and tax identification number

Q38. How long do I have to file a claim?

A38. If you utilize a Participating provider, the provider should file your claim to Blue Cross. For non-network providers, you have fifteen (15) months from the date of service to file the claim.

Q39. A provider has billed me, how do I know how much of the bill to pay?

A39. After your claim is processed, you will receive an Explanation of Benefits (EOB). The EOB is not a bill. It simply summarizes services received, how the claim was paid and what you are responsible for paying. Compare the bill the provider sent you to the Explanation of Benefits Blue Cross has sent your regarding the disposition of the claim. If you utilized a Participating provider, you will not be responsible for the amount over eligible charges.

Q40. How can I check the status of my claim?

A40. Blue Cross of California provides our members secure online services as part of our commitment to serving your many health care needs.

Within the Member section you can:

- Login to research your health plan benefits and exclusions.
- View status of current claims.
- Download plan enrollment forms at your convenience.
- Download medical forms and plan applications.
- Find out more about our Value-Added Programs.

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. You can also verify status of a claim with a dedicated customer service representative during normal business hours.

Q41. What is the difference between deductibles and co-payments?

A41. Co-payment is the amount of covered expense you are responsible for paying. Please refer to your Combined Evidence of Coverage for additional information.

Deductible is an amount the insured person must pay before benefit payments for covered services begin. The deductible is a set dollar amount determined by the member's contract, and is calculated based on the lower of the hospital/provider actual charges or the payment benefit. For example, a plan might require the member to pay the first $500 of covered expenses during a calendar year prior to Blue Cross providing payment for services rendered.

Q42. How does my out-of-pocket maximum work?

A42. Members are required to pay a copayment for services received as a Blue Cross member. The copayment amount may be a fixed dollar amount or a percentage of eligible charges. Once you reach the specified dollar amount, your plan may begin paying claims at 100% of eligible charges for the remainder of the year. 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. There may be separate copayment amounts for Participating and Non-Participating providers. Please refer to your Combined Evidence of Coverage for clarification.

Q43. What is Coordination of Benefits (COB)?

A43. 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.

Q44. Why did I receive a Coordination of Benefit Questionnaire and do I have to return it?

A44. 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.

Q45. What do I do with a foreign medical bill for care I received outside of the USA?

A45. The member should ask for the claim to be written in English and:

- Submit the itemized bill 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. (You are responsible, at your expense, for obtaining an English language translation of a foreign country provider claim and medical records.)
- 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.

Q46. I have a pending surgery. How do I determine my financial responsibility?

A46. You should always feel free to discuss costs with your doctor. You can also access cost information through this web site, via the link to the SUBIMO feature. This web site will often be able to give you an estimate of costs you will incur.

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Grievances & Appeals

Q47. What is the procedure for lodging a compliant against a provider?

A47. If you have a compliant about services from Blue Cross or your health care provider, please call Blue Cross first at the Customer Service number on your ID Card or you may send your complaint in writing. Customer Service is available from Monday through Friday, 8:30 AM to 12 midnight, (PST) Pacific time.

Q48. How do I appeal a disputed health care service pertaining to medical necessity or appropriateness of service?

A48. You may ask for a review from Blue Cross of California or BC Life & Health Insurance Company. You may submit a written request to the following address:
Blue Cross of California
Grievance and Appeal Management
P.O. Box 4310
Woodland Hills, CA 91367

If you have a compliant about services from Blue Cross or your health care benefits, please call Blue Cross first at the customer service number on your ID card.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form to complete and return to us, or ask the customer service associate to complete the form for you over the telephone. Your issue may then become part of our formal grievance process and will be resolved accordingly.

Q49. 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?

A49. First, make sure you call us at the Customer Service number shown on your Member ID Card to discuss the specifics of your case. If your coverage is from Blue Cross of California and you are still dissatisfied with the outcome, you may contact the California Department of Managed Health Care (DMHC); or if your coverage is from BC Life & Health, you may contact the California Department of Insurance (DOI).

If your case involves an imminent threat to your health including, but not limited to, the potential loss of life, limb or major bodily function, you may not be required to complete the Blue Cross of California appeal process or to wait at least 30 days, but may immediately submit your grievance to the DMHC or DOI for review. You may be eligible for an independent medical review, which is handled through the DMHC or DOI and a contracted independent medical review organization.

You can reach the DMHC by calling toll-free (888) HMO-2219 or by visiting their web site at http://www.hmohelp.ca.gov

You may reach the DOI by calling toll-free (800) 927-HELP (4357) or by writing to them at:

Department of Insurance, Consumer Affairs Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013

ERISA: If you 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.

Independent Medical Review of Grievances involving a Disputed Health Care Service: You may request an Independent Medical Review ("IMR") of disputed health care service from the Department of Managed Health Care (DMHC) if you believe that we have improperly denied, modified, or delayed health care services, including denials for investigational services. A "disputed health care service" is any health care service eligible for coverage and payment under your plan that has been denied, modified, or delayed by us, in whole or in part, because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form with any grievance disposition letter that denies, modifies or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. Please see you Evidence of Coverage for more information on how to initiate the IMR process.

Q50. What if waiting for you to decide on my appeal would harm my health?

A50. 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.

Q51. My Explanation of Benefits says I received services that I did not have. What should I do?

A51. Please call the Customer Service number on your ID Card for assistance. Customer Service is available from Monday through Friday, 8:30 AM to 12 midnight, Pacific time.

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General Information

Q52. How do my PPO benefits work?

A52. We have established a network of "Participating Providers". These providers are called "participating" because they have agreed to participate in our preferred provider organization program (PPO). .

Receiving services from the Blue Cross PPO Provider network can substantially reduce your out-of-pocket costs. These lower costs are due to negotiated rates that Blue Cross PPO Providers have agreed to accept. These providers should file claims to Blue Cross for our members, then bill you for the remaining portion of their eligible charges.

Q53. What happens to my coverage if I move out of the area?

A53. Please contact our Customer Service Department at the number on your ID Card and request that your file be updated with your new address. This request may be required in writing.

Q54. What happens to my coverage if I quit my job or I'm laid off or fired?

A54. 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.

Q55. What happens to my coverage if I turn 65?

A55. Your group size will determine if Medicare or Blue Cross will remain your primary coverage. Please see your Combined Evidence of Coverage or call customer service for more details.

Q56. What happens to my coverage if I retire?

A56. When you retire, you may become eligible for COBRA/Cal-COBRA coverage. Please refer to your Combined Evidence of Coverage for more details. You should know that the responsibility of premium payment may be your sole responsibility.

Q57. What if I become disabled?

A57. If you are a totally disabled subscriber and under the treatment of a physician on the date of discontinuance of the Benefit Agreement your benefits may be continued for treatment of the totally disabling condition. Please refer to your combined Evidence of Coverage and Disclosure Form for more details.

Q58. What if my spouse and I divorce?

A58. 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.

Q59. Is my child covered while in college?

A59. Unmarried children from their 19th to their 24th birthday who qualify as dependents for federal income tax purposes and who are full time students, with proper verification, may remain covered under the subscribers policy. Requires written verification of enrollment annually for approval of continued coverage.

Q60. Do I have coverage for pre-existing conditions?

A60. Not until you've been enrolled in the plan for six months. If you were enrolled in another medical plan within sixty-three (63) days of enrollment with Blue Cross of California then Blue Cross will credit the time spent under coverage to reduce or eliminate the six-month waiting period.

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