

# **BCC INDIVIDUAL HMO MEMBERS**

## **Members' Frequently Asked Questions About Blue Cross of California Individual HMO Health Plans**

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

- [Customer Service](#)
- [Enrollment](#)
- [ID Cards](#)
- [Physicians and Other Providers](#)
- [Approvals and Referrals](#)
- [Emergency Care](#)
- [Travel Coverage](#)
- [Pharmacy](#)
- [Claims](#)
- [Grievances and Appeals](#)
- [General Information](#)

## **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. To safeguard your personal information, you must receive a personal identification number (PIN) 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, Pacific time. You will also find detailed information about your plan or benefits by reviewing your Evidence of Coverage booklet. If you have any

questions regarding the information, call our Customer Service number on your ID Card.

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

**A2.** Connect to Customer Service via our interactive [Member Services](#) feature 24 hours a day, 7 days a week. 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.

To safeguard your personal information, you must receive a personal identification number (PIN) 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, Pacific time.

## **Q3. How do I change my name or address?**

**A3.** Please call the toll-free Customer Service number on your ID Card 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 60007  
Los Angeles, CA 90060-0007

Or you may fax the change to our membership department: 800-327-9255

If you move more than 30 miles from your Medical Group or IPA, call Customer Service to select a new Medical Group or IPA.

## **Q4. What are your customer service hours?**

**A4.** Customer Service is available Monday through Friday from 8:30 a.m. to 12:00 Midnight, Pacific time. Our automated, interactive voice response (IVR) system is available 24 hours a day/7 days a week.

## **Q5. How do I get a provider directory?**

**A5.** You can get a directory of Blue Cross HMO providers as follows:

- You may find a Blue Cross HMO provider using this web site to link to [Provider Finder](#). The most current resource for finding a provider is the web site.
- 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, Pacific time.
- 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.

[\[Back to top\]](#)

## ***Enrollment***

### **Q7. How can I cover my newborn from birth?**

**A7.** Newborns are covered for the first 31 days of life.

Requests for enrollment of newborn children must be made within the first 60 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 60 days from the date of birth. If Blue Cross receives this request on the day following the 60<sup>th</sup> 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.** The adopted child of a Subscriber is automatically covered for 31 days from the date on which the adoptive child's birth parent or appropriate legal authority signs a written document granting the Subscriber or enrolled Spouse the right to control health care for the adoptive child.. To continue

coverage beyond 31 days, the adopted child must be added 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. A copy of the final adoption paper is required with the application.

### **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 one (31) 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 one (31) 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**

To delete a family member from a policy, Blue Cross must receive this request 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.** 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. Call the

Blue Cross of California Customer Service number on your ID Card and ask for information about guest membership.

**Q11. How often can I change benefit plans?**

**A11.** You may change your existing benefit plan once per calendar year. There are different steps involved in changing your plan depending on if you are upgrading or downgrading your plan. If you have questions on changing your existing benefit plan, please contact a dedicated Customer Service Associate at the number on your ID card or contact your broker.

**Q12. How long can my children remain covered?**

**A12.** Your children remain covered if they are unmarried, under 19 years old, or 22 years old or younger as long as they qualify as dependents for income tax purposes and are full-time students (12 or more credits) at an accredited college, university, vocational or technical school. Blue Cross requires written proof of student status annually. Please see your Evidence of Coverage booklet/policy for more details.

The age limit for children to remain on your policy is 23 years old. At that time, they may transfer to their own Individual plan.

**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.

**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.

[\[Back to top\]](#)

## ID Cards

### **Q15. How do I order additional ID Cards?**

**A15.** Please use the [Member Services](#) feature to order ID Cards, or you may call the toll-free Customer Service number on the back of your ID Card. Customer Service is available from 8:30 a.m. to Midnight, Monday through Friday, Pacific time.

(800) 333-0912

### **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.

[\[Back to top\]](#)

## 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. If you want directions to a specific provider, 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 your health care. Primary Care Physicians include general and family practitioners, internists and pediatricians. Certain

specialists, we may approve, may also be designated Primary Care Physicians.

**Q19. What are the advantages of using network providers?**

A19. Under the HMO plan, you are only covered for services through the network provider that is designated as your Primary Care Physician, unless you need emergency services or urgent care.

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

A20. You may be able to nominate him or her. Call our Customer Service number on your ID Card.

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

A21. You can call our Customer Service number on your Member ID Card. We will need to know why you want to change your medical group. Try to call Customer Service by the 15th of the month so that your change can become effective on the first day of the following month. Changes are not allowed if you are in a course of a medical treatment. You may also connect to Customer Service via our interactive [Member Services](#) feature.

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

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

- If you move and your new residence is not within the enrollment area of your current medical group, you must request a transfer to another medical group. Call the Customer Service number on your ID Card or file a Membership Change form within 31 days of your move. You may request a Membership Change form by calling Customer Service.
- Under special circumstances, you can request a transfer by calling the Customer Service number on the back of 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. Contact the Blue Cross HMO coordinator at your medical group.

**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 or 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 through a network provider, unless you need emergency services or urgent care. If you go to a non-network provider, you will have to pay for it yourself.

**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.

**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. If necessary you may be referred to any HMO contracting specialist or any specialist that has the expertise to provide the care you need for your condition or disease.

**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 disruption 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 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 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.

[\[Back to top\]](#)

## Approvals and Referrals

### **Q30. What services require prior approval or referral?**

**A30.** Members must obtain referrals from their Primary Care Physician (PCP) for any services that the PCP or assigned Medical Group does not perform. 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.

- 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.
- You will need to make the appointment at the other 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 any care you seek is authorized because you are responsible to pay for services that are not authorized.

### **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.

[\[Back to top\]](#)

## **Emergency Care**

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

**A34.** Call 911 or seek immediate treatment at the nearest facility. If you are admitted to a hospital, ask for the Blue Cross HMO to be contacted immediately. Review your Evidence of Coverage booklet 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.

[\[Back to top\]](#)

## **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.

#### **Outside of California**

If you are traveling outside California, and need health care because of a sudden non-emergency illness or injury, call the BlueCard Access 800 number on your member ID Card. The BlueCard Access Call Center will tell you if there are doctors or hospitals in the area that can give you care. They will give you the names and phone numbers of nearby doctors and hospitals that you can go to or call for an appointment.

#### **Outside of California for more than 90 days**

If you or your family members will be away from home for more than 90 days, you may be able to get a guest membership in a medical group in the

city you are visiting. Before you leave home, call the Blue Cross HMO Customer Service number on your member ID Card. Ask for the Guest Membership Coordinator. We will send you forms to fill out. If there is a medical group taking part in the national network in the city you will be visiting, you'll be a guest member while you're away from home. The benefits you get may not be the same as the benefits you would get at home.

**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 must call us within 48 hours or as soon as medically possible. Review your Evidence of Coverage booklet for more details.

[\[Back to top\]](#)

## 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](http://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 a prescription 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](http://www.bluecrossca.com) or call (800) 700-2541. Have the pharmacist fill out the form and sign it. Then send the claim form (within 90 days) 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.

[\[Back to top\]](#)

## 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. HMO providers and hospitals participating under our standard business contracts will submit claims on the member's behalf. Other providers may require members to submit their own claims. 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. 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.** Under the HMO plan, your provider will bill us directly. If you should receive a bill, do not ignore it. Please call us at the number on the back of your ID card. As quickly as possible, send a copy 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.** This question does not apply for HMO members.

**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. How does my co-pay limit work?**

**A50.** 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.

**Q51. What is Coordination of Benefits (COB)?**

**A51.** Coordination of Benefits do not apply to Individual members.

**Q52. Why did I receive a Coordination of Benefit Questionnaire and do I have to return it?**

**A52.** Coordination of Benefits do not apply to Individual members.

**Q53. What do I do with my foreign medical bill for care I received outside of the USA?**

**A53.** When receiving services in a foreign country, 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.

**Q54. How is a substance abuse claim paid through my coverage? Do I need a referral?**

**A54.** Services for substance abuse/chemical dependency may only be utilized at an inpatient alcohol or drug abuse detoxification facility. Your Primary Care Physician will need to provide you with a referral for the inpatient stay. A claim will be submitted on your behalf by the inpatient facility that you attend. Please contact Customer Service at the number on your ID card for more information.

[\[Back to top\]](#)

## Grievances & Appeals

### **Q55. What is the procedure for lodging a complaint against a provider?**

**A55.** 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.

### **Q56. How do I appeal a disputed health care service pertaining to medical necessity or appropriateness of service?**

**A56.** You may ask for a review from Blue Cross of California. Call us at the Customer Service number shown on your ID Card or write to us at the following address:

Blue Cross of California  
Grievance and Appeal Management  
P.O. Box 9041  
Oxnard, CA 93031

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.

### **Q57. 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?**

#### **A57.**

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.*

**Q58. What if waiting for you to decide on my appeal would harm my health?**

**A58.** 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.

**Q59. My Explanation of Benefits says I received services that I did not have. What should I do?**

**A59.** Explanation of Benefits are not sent to HMO members. If you receive one, please call the Customer Service number on your ID Card for assistance.

**Q60. If I feel I need a second opinion, how do I go about obtaining one?**

**A60.** 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.

[\[Back to top\]](#)

## *General Information*

**Q61. How do my HMO benefits work?**

**A61.** 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.

**Q62. What happens to my coverage if I move out of the area?**

**A62.** 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.

**Q63. What happens to my coverage if I quit my job or I'm laid off or fired?**

**A63.** Nothing. You are covered under an Individual Member plan, and it is not effected by your employment.

**Q64. What happens to my coverage if I turn 65?**

**A64.** Members who are 65 years of age or older may apply for a Blue Cross Senior plan which supplements Medicare benefits. Call a dedicated Customer Service Associate at the number on your ID card for more information.

**Q65. What happens to my coverage if I retire?**

**A65.** Nothing. You are covered under an Individual Member plan, and it is not effected by your employment.

**Q66. What if I become disabled?**

**A66.** A number of options may be available to you, please contact a dedicated Customer Service Associate at the number on your ID card to discuss the best option for you.

**Q67. What if my spouse and I divorce?**

**A67.** The dependent spouse may transfer to his/her own Individual plan. Please contact a dedicated Customer Service Associate at the number on your ID card to receive instructions.

**Q68. Is my child covered while in college?**

**A68.** You and your family members do not have to enroll in the same medical group. For your college age student (from 19 to 22 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.

**Q69. Do I have coverage for pre-existing conditions?**

**A69.** All pre-existing conditions are covered under your HMO plan if disclosed on your application at the time of enrollment.

[\[Back to top\]](#)