

BCC INDIVIDUAL PPO MEMBERS

Members' Frequently Asked Questions About Blue Cross of California or BC Life & Health Insurance Company Individual PPO Health 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. 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 or BC Life & Health

Insurance policy. If you should 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 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 9051
Oxnard, CA 93031-9051

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

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

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 PPO (Prudent Buyer) providers as follows:

- Link to [Provider Finder](#) on our web site. 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.
- 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 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 60th 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.

You may send your request to:

Blue Cross of California
P.O. Box 9051
Oxnard, CA 93031-9051

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

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

A10. Your unmarried child is covered while in college, provided that he or she is enrolled as a full-time student and is age 22 or younger whether living out-of-state or not.

Access the information through www.bluecares.com, the Blue Cross Blue Shield Association's Web site. Simply click on the Blue Card Doctor & Hospital Finder hotlink and complete the requested information to locate a PPO provider as close as five miles from your location. To find a participating BlueCard provider outside of California, simply call BlueCard Provider Access toll-free at 1-800-810-BLUE. The toll-free BlueCard Provider Access number is also printed on the back of your ID Card.

Q11. How often can I change benefit plans?

A11. You may change your existing benefit plan as often as you like. 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.

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ID Cards

Q14. How do I order additional ID Cards?

A14. Please use the [Member Services](#) feature to order ID Cards. Or, call the toll free Customer Service number on the back of your ID Card to order new ID Cards. Customer Service is available from 8:30 a.m. to Midnight, Monday through Friday, Pacific time.

(800) 333-0912

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 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. Blue Cross Individual Services issues ID cards with the subscribers name only. Dependents names are not listed.

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. No.

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Physicians and Other Providers

Q18. How do I find a network provider?

A18. 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 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 agree to accept instead of their typical fees, and generally, benefits paid for non-participating providers are more limited. You do not need to make payment for services, unless your plan has an office visit copay, 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. You do not have to file a claim form for services rendered by Blue Cross PPO providers.

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. If you utilize the services of 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. Yes, you may go to a non-network provider, but your out-of-pocket costs will be substantially less if you go to a Participating Provider. Please consult your Evidence of Coverage.

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Approvals and Referrals

Q22. What services require prior authorization?

A22.

Prior authorization is required for:

- All inpatient Hospital and Skilled Nursing Facility stays (except inpatient Hospital stays for the delivery of a Child, Mental or Nervous Disorders and Substance Abuse, or mastectomy surgery, including the length of Hospital stays associated with mastectomy).
- Home health visits.
- All Organ and tissue transplants and peripheral stem replacement and similar procedures and Coronary Artery Bypass Surgery.
- All infusion therapy and related service in any setting.
- The following diagnostic procedures wherever performed:
 - Magnetic Resonance Imaging (M.R.I.) of the spine only.
 - Computerized Axial Tomography (CAT Scan) of the spine only.
 - Positron Emission Tomography (PET Scan)
- The following specified surgical procedures wherever performed:
 - Septoplasty
 - Knee arthroscopy

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), you will 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. If you select a specialist that participates in the Blue Cross PPO Network, a referral is not required.

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.

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Emergency Care

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

A26. Call 911 or seek immediate treatment at the nearest facility.

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 health care because of a sudden non-emergency illness or injury, call the BlueCard Access 800 number on the back of your member ID Card, 1-800-810-BLUE. The BlueCard Access Call Center will tell you if there are doctors or hospitals in the area that can give you care. 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 or urgent condition, 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. You may seek services at any of our participating providers.

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 30 or 60 day supply, plus refills when appropriate. Secure a mail order form by clicking [here](#) or call Customer Service at the number on your ID card. Fill out the mail order form. Return it along with your prescription and any necessary copayment to PrecisionRx at P.O. Box 961025, Fort Worth, Texas, 76161-9863. Their 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.

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. 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) 700-2541. 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

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 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 or if you are planning to go out of the country, please call the toll-free pharmacy Customer Service number listed on your ID card.

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 you, then bill you for remaining portion of their charges. If you receive services from Non-Participating providers, you will need to submit a claim to Blue Cross of California. You can get a claim form by downloading the claim forms from our Web site, 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.

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

A38. Fifteen (15) months from the date of service in order to be eligible for benefits. We are not liable for the benefits of the plan if claims are not filed within this time period.

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.

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

A40. 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. 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 Representative will assist you.

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

A41. 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.

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

A42. Out-of-pocket maximum refers to the most you pay for covered expenses during the year before your 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, as determined by your contract, 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.

Q43. What is Coordination of Benefits (COB)?

A43. Coordination of Benefits (COB) does not apply for Individual members.

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

A44. Coordination of Benefits does not apply to Individual members.

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

A45. When receiving services in a foreign country, 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 how much I will be responsible for to pay?

A46. You should always feel free to discuss costs with your doctor. You can also access cost information through our web site, via the link to the SUBIMO web site. 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 complaint against a provider?

A47. Please call the Customer Service number on your ID Card. Customer Service is available from Monday through Friday, 8:30 AM to 12 midnight, 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 9086
Oxnard, CA 93031-9086

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 three (3) days if your case involves an imminent threat to your health and should be expedited.

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. You may file an appeal with Blue Cross of California or BC Life & Health Insurance Company. Call us at the Customer Service number shown on your Member ID Card. Your issue may then become part of our formal grievance process and will be resolved accordingly. If your coverage is from Blue Cross of California and you are dissatisfied with the resolution through the formal grievance process, 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

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.

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 belayed 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 your 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 listed 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". They have agreed to provide our members with health care at a special negotiated rate. The amount your plan pays will be different for a Non-Participating Provider than for a Participating Provider. Please refer to your Evidence of Coverage booklet for more information.

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

A53. Please call the Customer Service number on your ID Card and request that your file be updated with your new address.

Q53. What happens to my coverage if I quit my job or I'm laid off or fired?

A53. Nothing. You are covered under an Individual policy, and it is not changed when your employment changes.

Q54. What happens to my coverage if I turn 65?

A54. Members who are 65 years of age or older may apply for a Blue Cross Senior Plan which supplements Medicare benefits. Please call a dedicated Customer Service Associate at the number on your ID card.

Q55. What happens to my coverage if I retire?

A55. Nothing. You are covered under an Individual policy, and it is not changed when you retire.

Q55. What if I become disabled?

A55. This does not apply for Individual members.

Q56. What if my spouse and I divorce?

A56. The dependent spouse may transfer to his/her own Individual plan. Please contact customer service at the number on your ID card to receive instructions.

Q57. Is my child covered while in college?

A57. He/she is covered as long as:

- he/she is an unmarried child of the subscriber or the enrolled spouse and
- is under 23 years of age, and
- qualifies as a dependent for federal income tax purposes.

We may require annual tax form verification and written proof of student status in writing.

Q58. Do I have coverage for pre-existing conditions?

A58. Not until you've been enrolled in the plan for six months. If you were enrolled in another medical plan within 63 days of enrollment with Blue Cross of California/BC Life & Health then we will credit the time spent under coverage to reduce or eliminate the six-month waiting period.

The maternity benefit is in effect only if you conceive on or after your effective date.

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