For Groups

Understanding Your Health Care Coverage
For Your Information
This brochure contains highlights about how your HMO coverage works. In it you will find helpful information about HMOs and tips on how to access your BlueCare coverage and benefits. Also, visit our website at www.bcbsfl.com. Please remember that this is not a contract, nor is it a summary of the benefits available under your contract. In this regard, you will find it helpful to refer to your Member Handbook.

Please remember that your Member Handbook defines:
• the benefits available under your coverage
• what is covered
• what is not covered; and
• any limits or exclusions applicable to your coverage

The words “you” or “your” in this brochure refer to the people who are covered by Health Options. The words “us,” “we” and “our” refer to Health Options, Inc.

We can serve you best when our records are kept up-to-date. So, if your address or telephone number changes, or if you have any questions, please call us as soon as possible at the number listed on your Health Options membership card.

The more you know about your health care and how your coverage works, the easier it will be for you to maximize the value of your benefits. We want you to be a well-informed health care consumer.

Welcome to BlueCare from Health Options 2
What is Health Options? 3
What is an HMO? 4
What Does “Managed Care” Mean? 5
Choosing Your Primary Care Physician 6
Arranging Office Visits 8
When You Need to See a Specialist 9
Handling an Emergency 10
Going Into the Hospital 11
Membership in Health Options 12
How Health Options Makes a Coverage Decision Regarding Medical Necessity 14
Complaint and Grievance Process 15
About Confidentiality 18
Coverage for You and Your Family 19
A Brief Description of Covered Services 20
Working to Control Health Care Costs 22
Members’ Rights and Responsibilities 24
Advance Directives 26
Terms to Understand 27
Questions and Answers 28
Welcome to BlueCare from Health Options

Since we know everyone has different needs, each family member can choose his or her own personal doctor, called a Primary Care Physician (PCP), from our list of PCPs. Our network contains some of the same community physicians with whom you are familiar. Your PCP will get to know you and your medical history and will help you coordinate your medical services.

You’ll find most of the medical services covered by BlueCare have low, predetermined copayment amounts. This helps you to know beforehand what your out-of-pocket costs will be.

Please refer to your Schedule of Copayments for a detailed list of copayments.

Health Options North and South has been accredited by the National Committee for Quality Assurance (NCQA), an independent, non-profit organization located in Washington, DC, that assesses the quality of managed care organizations. Health Options has received Commendable accreditation in its North Geographic Business Unit and has an Excellent status in its South Geographic Business Unit. NCQA evaluates how well a health plan manages its network of physicians, hospitals, and other providers in order to continually improve the health care coverage experience for its members. Health Options meets NCQA’s rigorous standards for accreditation. Please take a few minutes now to read the following pages. We want to help you learn more about the health care coverage and value we bring to you and your family.

You’ve chosen BlueCare from Health Options because you want the best health care coverage possible. We want the best for you too. That is why we have dedicated ourselves to providing Floridians like you with affordable, reliable health care coverage.

And because staying healthy is just as important as getting well, we put an emphasis on preventive care and wellness benefits for you and each of your family members. Please see your Member Handbook for full details.

1Health Options, Inc. is the HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc.
What is Health Options?

Health Options, Inc., is a combination Individual Practice Association (IPA)/Network model Health Maintenance Organization (HMO) and a wholly-owned subsidiary of Blue Cross and Blue Shield of Florida, Inc. For more than 50 years, Floridians like you have looked to the stability and experience of Blue Cross and Blue Shield of Florida to provide the security and peace of mind that come with affordable and reliable health care coverage. Following in this tradition, Health Options continually works to make sure that coverage is both affordable and reliable.

As an IPA/Network model HMO, Health Options is responsible for making coverage and payment decisions based on the terms of your Member Handbook. Health Options does not provide medical care or treatment nor does it make care or treatment decisions.

As a member of Health Options you, your family, and most importantly, your physician or health care provider are responsible for all care and treatment decisions regarding the care you and your family members receive. The use of financial incentives by Health Options is intended to encourage physicians and other health care providers to minimize the provision of unnecessary services, reduce waste in the application of medical resources, and to eliminate inefficiencies which may lead to the artificial inflation of health care costs. These incentives are also intended to improve doctor-patient relationship satisfaction. Health Options wants you and your family members to know that your physician's or health care provider's decisions regarding whether or not to provide medical care and treatment may affect the amount of money your physician or health care provider earns. For example, Health Options may prepay your physician or health care provider a set amount per month to cover the cost of providing services to you and your family members whether or not he or she actually renders care during that month. This form of provider payment is called capitation. If this predetermined amount of money paid to your physician is less than what it actually costs your physician to provide care to you or your family members, your physician may lose money. Of course, Health Options wants and expects that your physician will recommend treatment alternatives that are medically appropriate for you. However, if you have concerns in this regard, we strongly encourage you to discuss with your physicians and other health care providers how their acceptance of financial risk may affect your medical care or treatment.

Health Options Uses Provider Financial Incentives

In order to keep the premiums you pay for your coverage affordable, Health Options attempts to hold down the cost of health care. Health Options does this in several ways. One of the ways that may be used by Health Options to help hold down the cost of health care is offering financial incentives to physicians and other health care providers, through one or more kinds of compensation arrangements (e.g., capitation, and participation in “risk pools” and fee “withhold” arrangements), to deliver cost-effective medically appropriate health care services.

Financial incentives in compensation arrangements with physicians and other health care providers is one method by which Health Options (and other HMOs) attempt to reduce and control the costs of health care. Other approaches include efforts to assist members to stay healthy through education and the offering of certain preventive health benefits such as mammograms.

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What is an HMO?

A Health Maintenance Organization (HMO) is an alternative health care financing and/or delivery organization that either provides directly, or through arrangements made with other persons or entities, comprehensive health care coverage and benefits or services, or both, in exchange for prepaid per capita or prepaid aggregate fixed sum. HMOs often use provider financial incentives and apply so called “managed care” principles and techniques to coverage and benefit decisions in order to promote the delivery of cost-effective medically appropriate health care services. See the section, “What Does ‘Managed Care’ Mean?”

In recent years, HMOs have grown increasingly popular because there are no deductibles to satisfy and members are covered for a wide range of health care services with little or no out-of-pocket costs. Additionally, many HMOs put a special emphasis on preventive care benefits for periodic health assessments and immunizations.

Types of HMOs

While some HMOs are similar, not all HMOs operate or are organized in the same way. For example, an HMO can be organized and operate as a Staff model, a Group model, an Individual Practice Association (IPA) model or a Network model. Here are a few important ways these types of HMOs differ:

Staff and Group Model HMOs

In a Staff model HMO, the doctors and other providers providing care are usually salaried employees of the HMO and generally provide care in a clinic setting rather than in their own personal offices. Group model HMOs, on the other hand, contract with large medical group practices to provide or arrange for most health care services. Typically, the HMO is owned by the doctors in the medical groups. In both these models, the HMO’s doctors and other providers typically do not see patients covered by other third party payers or managed care organizations.

IPA and Network Model HMOs

In an IPA model HMO, the HMO typically contracts with individual, independent doctors and/or a physician organization, which may in turn contract services with additional doctors and providers. Unlike the Staff or Group model HMOs, the IPA model HMO does not provide health care services itself. Instead, it pays independent, qualified providers to provide health care to its members. The doctors in an IPA model HMO are not the agents or employees of the HMO; they typically practice in their own personal offices, and continue to see patients covered by other third party payers or managed care organizations.

In a Network model HMO, the HMO contracts with individual, independent doctors, IPAs, and/or medical groups to make up a health care network. Unlike the Staff or Group model HMOs, the Network model HMO does not provide health care services itself. Instead, it pays independent, qualified providers to provide health care. The doctors in a Network model HMO are not the employees of the HMO and typically practice in their own personal offices. Like the IPA model HMO, doctors under contract with a Network model HMO usually continue to see patients covered by other third party payers or managed care organizations.

Please note: This description is not intended to be an exhaustive listing of all HMO organizational models in use in the United States.

Health Options is a combination of an IPA and a Network model HMO. It is not a Staff or Group model HMO. This means that the doctors and other providers with whom it contracts are independent contractors and not the employees or agents, actual or ostensible, of Health Options. Rather, these independent doctors and providers typically continue to see their own patients in their own personal offices or facilities and continue to see patients covered by other third party payers or managed care organizations.
The term “managed care” is used to describe the processes or techniques generally used by some HMOs and other third party payers to promote the delivery of cost effective medically appropriate health care services. Managed care techniques can be used with services performed by doctors or other providers of health care. They most often include one or more of the following: prior and concurrent review, for coverage and payment purposes, of the medical necessity of services or site of services; financial incentives or disincentives related to the use of specific providers, services, or service sites; coordinated access to medical care, and coordination of services by a case manager or primary care physician; and payer efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

These managed care techniques can help offset the rising cost of health care and provide relief in the way of limiting out-of-pocket costs to consumers.

**Does Health Options use managed care techniques?**

Health Options uses managed care techniques including prior and concurrent review, for coverage and payment purposes, of the medical necessity of services or site of services. Health Options also uses provider financial incentives. For additional information, see “Health Options Uses Provider Financial Incentives” on page 3 and “How Health Options Makes a Coverage Decision Regarding Medical Necessity” on page 14 in this booklet.
Choosing Your Primary Care Physician

We want you to be comfortable with your doctor. It's important to have a doctor who knows your medical history to coordinate your care and help you make informed decisions. Your Primary Care Physician (PCP), chosen from our network of health care providers, should be someone you trust and can talk with easily. Take time to get to know your PCP.

To make sure your whole family receives the individual care and attention they need, each family member may choose a PCP from our network of providers. Or if you prefer, one PCP can coordinate care for your entire family.

A Provider Directory is Part of Your Enrollment Package

You should refer to the provider directory that is part of your enrollment package for a list of the health care providers who are part of the Health Options network and are available in the area where you live. You may also visit our website at www.bcbsfl.com. Our online provider directory gives you the most up-to-date information about our providers, including their contracting status. Even so, always confirm your providers’ contracting status with Health Options or when making an appointment.

If you wish to check a provider’s education, licensing credentials, or board certification, you may call the Department of Health at 1-850-488-0595. Should you wish to file a complaint against a provider or check the status of a disciplinary action against a provider, you may call the Agency for Health Care Administration (AHCA) Information Center at 1-888-419-3456 and press 2 after the prompts.

Transfer Your Medical Records

If the PCP you’ve chosen is not your current physician, you should contact your current doctor and ask to have your medical records transferred to your new PCP.

Get to Know Your PCP

You don’t have to wait until you are sick to meet your new doctor. It’s a good idea to make an appointment to meet your new doctor and go over your medical history. Ask your doctor questions if you don’t understand his or her instructions for your treatment. You should also bring any medications you are currently taking to your PCP to obtain updated prescriptions. Your PCP will provide and help you coordinate your medical care.

By taking the time to meet your new doctor, you and your PCP can build a sound relationship, which is the first step in assuring your good health.
Get to Know Your PCP

Follow the procedures below to get started:

1. Make it a point to know your PCP for yourself and each of your dependents.

2. Call your PCP for your initial visit and any health care needs.

3. Always show your membership card before you receive health care services and supplies.

Changing Your PCP

We encourage you to maintain a relationship with a PCP you can trust with your health care concerns. We understand there may still be instances when you may want to change to a new PCP.

You may change your PCP by selecting a new one from your provider directory. Simply call the Customer Service telephone number on your Health Options membership card to make the change. If you call to make the change before the 15th of the month, the effective date will be the first day of the following month. For example, if you call on October 10, the effective date of change will be November 1. If you call after the 15th, the change will not be effective until the second month from the date you call. For example, if you call on October 20, the effective date of change will be December 1. Until the change is effective, you must continue to receive medical services from your current PCP.
Arranging Office Visits

For routine office visits, call your PCP’s office and schedule your appointment. Make sure you inform your doctor’s office that you are a Health Options member and take your membership card with you to your appointment.

If you need to cancel a visit to your doctor, please give the office at least 24 hours notice.

Please remember these important TIPS:

- You don’t have to wait until you’re sick to get to know your new PCP. If you haven’t already done so, make an appointment with your PCP so he or she can get to know you and your medical history. This way you and your PCP can build a sound relationship which is the first step in assuring your good health.

- Make sure to have your PCP provide or refer all your medical care. If you receive medical care without going through your PCP, you are responsible for the costs of any care provided except in case of emergency.

- Services rendered outside of the service area, that aren’t an emergency, must be authorized in advance by Health Options in order to be covered services.

When Your Doctor’s Office Is Closed—After Hours Medical Care

You may need medical care when your PCP’s office is closed. If you have an emergency medical condition, go to the nearest hospital or closest emergency room or call 911.

If your medical condition is not an emergency, you should call your PCP. Your call will be answered by your PCP’s answering service. The answering service will ask you questions that may include your doctor’s name and a brief description of the reason for your call. The answering service will then call your PCP, who will call you back and give you instructions.

In the event of an emergency, always go to the nearest hospital emergency room or call 911.
When You Need to See a Specialist

If you need to see a specialist, call your PCP. Types of specialists you may be referred to include Cardiologists, Orthopedists, Obstetricians and many others.

BlueCare covers office visits to your PCP and to specialist offices with only a small copayment. Please refer to your Member Handbook for detailed information about your benefits and copayments.

Please remember these important TIPS:

- Having your PCP coordinate your medical care can save you time and money.
- If additional services or visits are suggested by the specialist, you must first call your PCP to get a referral.
- If you go to a specialist without a referral from your PCP, you are responsible for the costs of any care provided.

When You Don’t Need a Referral from Your PCP

A contracting provider is a health care provider who has entered into a contract with Health Options and is part of the Health Options network at the time you are seen by that provider. There are certain contracting providers that you can see without a referral from your PCP. They are:

**Chiropractors and Podiatrists:** You may visit a contracting Chiropractor or a Podiatrist, within the service area, who is listed in your provider directory without being referred by your PCP.

**Dermatologists:** You may visit a contracting Dermatologist, within the service area, for up to five visits per calendar year for office visits, minor procedures, and testing without being referred by your PCP.

**Gynecologists:** Women may visit a contracting Gynecologist, within the service area, for an annual routine examination without being referred by their PCP.

Refer to your provider directory for a listing of contracting providers, or call Health Options.

**Behavioral Health Providers**

Mental health and/or substance abuse treatment may be covered under your BlueCare plan. Please refer to your Member Handbook for detailed information on any mental health and/or substance abuse treatment coverage you may have and whether these services must be coordinated by your PCP.

Getting a Second Opinion

You may get a second medical opinion from a licensed physician in your service area under certain circumstances. You must notify your PCP first.

- You may get a second medical opinion if you disagree with Health Options, your PCP, or a contracting specialist’s opinion about the necessity of surgical procedures.
- You may get a second medical opinion if you are subject to a serious injury or illness.
- You may also request a second medical opinion if you feel you are not responding satisfactorily to treatment.

Health Options may require you to get a second medical opinion. Please refer to your Member Handbook for details.
Handling an Emergency

**In the event of an emergency, go to the nearest hospital emergency room or call 911.**

With BlueCare, you have coverage for emergency services 24 hours a day, 7 days a week. So whether you’re at home or on the road, your benefits work to get you the care you need.

If you have an emergency, go to the nearest emergency room for treatment. After you receive treatment, call your PCP or have someone call for you as soon as possible. You do not have to be referred by your PCP when you receive emergency services and care. However, please remember that it is your responsibility to let Health Options know as soon as possible about your emergency services and care and/or any admission to a hospital that may be needed because of your emergency condition.

Follow up care to your emergency condition must be coordinated by your (or your family member’s) PCP. If follow-up care is not provided by or coordinated by your PCP, coverage for that care may be denied and you may be responsible for the costs of that care.

**In the Emergency Room**

If you go to the emergency room for services and care and it is determined that an emergency does not exist, you will be responsible for all charges.

**Emergencies Out of Your Service Area**

If you go to an emergency room while you are out of the Health Options service area, present your membership card. Depending on the hospital’s billing policy, the bill for emergency services and care will be sent directly to Health Options or to you. If you receive a bill for emergency services and care, send the unpaid bill to Health Options with an explanation regarding the nature of the emergency. You’ll find our address on your Health Options membership card.

Please refer to your Schedule of Copayments for the emergency services and care copayment.
Going Into the Hospital

When you need hospital care or surgery, your PCP or specialist will arrange your hospital admission and coordinate your care.

Some hospital benefits require copayments. Please refer to your Schedule of Copayments for detailed information on hospital copayments. Coordinating your care through your PCP will ensure that you receive the maximum benefit.

Important Tip: Remember, your PCP or contracting specialist must coordinate your admission to a contracting Health Options hospital for non-emergency care, or you will be responsible for all hospital charges.
Membership in Health Options

Your Membership Card
Your membership card shows you are a Health Options member with BlueCare coverage. Your card is recognized throughout the medical community and serves as your key to network services. Keep your membership card with you at all times and show it to your providers any time you receive health care. Your membership card lists important telephone numbers such as the number for your PCP and your local Customer Service office.

If you lose your membership card, please call Health Options right away to get another card.

Prescription Drug Coverage
Your employer may have purchased a prescription drug endorsement. If so, simply take your prescriptions to a contracting pharmacy on the list included in your enrollment package.

For your convenience, our pharmacy network includes neighborhood and national companies, so you can get your prescriptions filled close to home or near your workplace. All you need to do is show your membership card and pay the copayment or other amount required.

Some prescription drug benefits may be subject to a Preferred Medication List. The Preferred Medication List is simply a list of medications that have been selected and reviewed by a panel of doctors and pharmacists. If your plan is subject to a Preferred Medication List, detailed information is included in your enrollment package. Please note that Health Options reserves the right to change the Preferred Medication List at any time.

Filing Claims
When you receive covered medical services and use providers who contract with Health Options, you will not have to file any claim forms. Contracting providers have either already been paid for their services or will file claims for you. Always be sure to show your membership card when you receive health care services.

If you receive emergency medical services and care from a provider who does not contract with Health Options, you will need to send your bill to Health Options at the address on your membership card.

Continually Looking at New Technology
The types of treatments, devices and drugs covered by BlueCare are extensive. In light of the rapid changes in medical technology, it is important to continually look at new medical advances and technology to determine which will be covered by your health care benefit package.

Before covering new medical technology, we look at a number of factors. Procedures and devices must be proven to be safe and effective by meeting certain criteria, among them:

• Approval by an appropriate government regulatory agency, such as the Food and Drug Administration (FDA)
• Scientific evidence of improved patient outcome when used in the usual medical setting, not just a research setting
• Benefit for patients is equal to established alternatives. To aid in decision-making, expert sources such as clinical studies published in respected scientific journals and physicians from various specialty medical organizations are consulted.

Because we strive to cover only treatments which have been proven to be safe and effective for a particular disease or condition, BlueCare does not cover experimental or investigational services. Experimental or investigational services are treatments that have not been proven safe and effective. Also, we try to determine, for coverage and payment purposes, if any new medical technology is superior to the treatments already in use.
Medical necessity means that, for coverage and payment purposes, a medical service or supply is required to identify, treat, or manage a condition. To decide if a medical service or supply is medically necessary for coverage and payment purposes, Health Options may consider one or more of the following:

• information provided by you or your physicians concerning your health status

• reports in medical literature concerning your condition or status or similar conditions and status

• reports or guidelines published by nationally recognized health care organizations and recognized by local physicians

• professional standards of safety and effectiveness

• the opinion of health care professionals in the health specialty involved

• the opinion of the attending physician(s)

• other information considered relevant by Health Options

A decision by Health Options that a medical service or supply is not medically necessary does not mean that you cannot get the treatment you want or that is recommended; it simply means that Health Options will not cover or pay for the service based on one or all the factors noted above. You are always free to get the service or supply and pay for it yourself. Please refer to your Member Handbook for detailed information on how medical necessity decisions are determined for coverage and payment purposes.
Complaint and Grievance Process

Health Options has a Complaint and Grievance Process in place for you so that any concerns you have about your health care coverage can be resolved. These concerns may involve coverage, benefit, or payment decisions. You may also have concerns about the quality of care that you receive from a contracting provider. If you do have a complaint or grievance, you must follow the process that is outlined in your Member Handbook. The information below is a summary of how the complaint and grievance process outlined in your Member Handbook works.

**Verbal Complaints**

If you have a verbal complaint, you may:

- call the Health Options Customer Service area at the telephone number that is on your membership card, or

- go to your local Health Options office in person (the address is in your Member Handbook under the Complaint and Grievance section) to file your verbal complaint.

The Customer Service area will review your verbal complaint with other Health Options staff if necessary. Your verbal complaint will be resolved within a reasonable amount of time.

**Written Grievances**

If you don’t agree with our response to your verbal complaint, you may file a written grievance. Please contact the Customer Service number listed on your identification card to verify the current mailing address.

1. **Local Office Review**

   **Standard Grievances** — To file a written grievance with your local Health Options office, please fill out a pink HOI Grievance Form (form number 16297 R1299 SR). You should have a copy of this form in your member package, or you may get the form by calling the Customer Service telephone number on your Health Options membership card. If you don’t have a form, you may also write a letter telling Health Options about the facts concerning your grievance. If you need help, our Customer Service Representatives can assist you in preparing the grievance. Hearing impaired members can contact Health Options via TDD. Please be sure to include as much detail as possible about your grievance. Send or take the letter to your local Health Options office. (Addresses and telephone/TDD numbers are listed on page 17.)

   We strive to resolve grievances in a timely manner. Although time frames vary between circumstances, Health Options will resolve your grievance within 30-60 working days of receipt, or within 90 working days if the grievance involves the collection of information from outside the service area.

   **Adverse Determination Grievances** — Health Options sometimes denies coverage and/or benefits for particular treatments, services, procedures or supplies based on a lack of medical necessity.

   When coverage is denied in these instances, referred to as “adverse determination,” you or a provider acting on your behalf can request further review of the decision by the Health Options Internal Review Panel. Health Options promptly and fairly considers and reviews all adverse determination grievances, which are governed by special rules.
Health Options’ Internal Review Panel, which reviews adverse determinations, consists primarily of physicians with appropriate expertise.

For your adverse determination to be reviewed by the Internal Review Panel, Health Options must receive the review request within 30 days from the date that you or your provider received a denial decision. To request this type of review, you or your provider must send a request in writing with supporting documentation within the 30-day time limit.

If Health Options does not receive your request for review by the Internal Review Panel within 30 days, the denial decision will be reviewed by the local Grievance Committee in accordance with the standard grievance procedure. Normally, local Grievance Committee review under the standard procedure takes approximately 30 working days.

For all other grievances you have one year from the date of your denied health care coverage to file.

2. Corporate Office Review

If you are not satisfied with the decision of your Health Options local office Grievance Committee, you may appeal to our Board of Directors Grievance Committee by sending a second grievance request in writing to the Health Options local office within 30 days of the local office decision. Just fill out the green HOI Grievance Appeal Form (form number 16298 R1299 SR). You should have a copy of this form in your member package, or you may get a copy of this form by calling the Customer Service telephone number on your membership card. You may also send a detailed letter to the Health Options local office Grievance Coordinator. The Health Options local office Grievance Coordinator will forward your grievance to the Corporate Office in Jacksonville, Florida. The Health Options Board of Directors Grievance Committee will review your grievance and give you an answer in writing as quickly as possible.

3. Statewide Provider and Subscriber Assistance Panel

If you are not satisfied with the second review of your grievance by the Health Options corporate office, you may send your grievance in writing to the Statewide Provider and Subscriber Assistance Panel within 365 days of receiving the Health Options corporate office decision. However, you must complete the entire Health Options Complaint and Grievance process—and receive a final disposition from Health Options—before pursuing review by the Statewide Provider and Subscriber Assistance Panel.

Send your grievance to the Statewide Provider and Subscriber Assistance Panel at the address listed below.

Statewide Provider & Subscriber Assistance Panel
2727 Mahan Drive
Bldg. 1, Room 339
Tallahassee, FL 32308
**Expedited Review of Urgent Grievances**

You may request a reconsideration of a denied service or benefit that you have not yet received. If you believe your life, health, or ability to regain maximum function could be seriously threatened if a service is not received, you may request a 72-hour review, called an expedited review. A provider acting on your behalf may also ask for an expedited review.

You or a provider acting on your behalf, must specifically request an expedited review. For example, this request may be made by saying: “I want an expedited review.”

Health Options will determine whether a review request meets certain criteria before handling it as an expedited review. If the criteria are met, Health Options will make a decision within 72 hours after receipt of the request. If your request does not meet the criteria for an expedited grievance, you may have the denied decision reviewed through the standard grievance procedure. A denial of payment for services already received does not qualify for an expedited review.

If you are not satisfied with Health Options’ decision, you may send your grievance in writing to the Statewide Provider and Subscriber Assistance Panel, 2727 Mahan Drive, Bldg. 1, Room 339, Tallahassee, FL 32308.

Please refer to your Member Handbook for detailed information about the Complaint and Grievance Process. If you need help or information after you have reviewed the Complaint and Grievance Process, call the Customer Service number listed on your Health Options membership card.

**Grievance Telephone Numbers and Addresses**

If a grievance is not resolved, you may contact an agency at the telephone numbers and addresses listed below at any time.

**Department of Insurance**

**Division of Insurance Consumer Services**

200 East Gaines Street
Tallahassee, FL 32399-0322
1-800-342-2762

**Agency for Health Care Administration**

**Bureau of Managed Care**

2727 Mahan Drive
Bldg. 1, Room 311
Tallahassee, FL 32308
1-850-922-6481
1-800-226-1062

**Statewide Provider & Subscriber Assistance Panel**

2727 Mahan Drive
Bldg. 1, Room 339
Tallahassee, FL 32308
1-850-921-5458
1-800-226-1062

**Health Options’ Local Office Addresses and Telephone Numbers**

You may contact a Health Options Grievance Coordinator at the Customer Service number listed on your membership card or the numbers listed below.

**Central Florida**

Health Options, Inc.
Attn: Grievance Department
4904 Eisenhower Blvd
Suite 200
Tampa, FL 33634-6330
1-800-583-9072
TDD 1-813-882-7681

**South Florida**

Health Options, Inc.
Attn: Grievance Department
8400 NW 33rd Street
Suite 100
Miami, FL 33122-1932
1-800-964-6595
TDD 1-800-818-4521

**North Florida**

Health Options, Inc.
Attn: Grievance Department
4900 Deerwood Campus Pkwy
Jacksonville, FL 32246-8273
1-800-734-6656
TDD 1-800-955-1339
About Confidentiality

You’ve entrusted us with your health care coverage. It is important to us that you know and understand we keep your records private as mandated by law and Health Options’ (HOI) policy. We also require that providers contracting with HOI maintain the confidentiality of your medical records held by them.

When you enrolled with us, you agreed to let providers give us the information we need to make coverage and benefits decisions for you. The information we need from your providers includes the diagnosis and history of your health care. Our contracts with providers require them to comply with confidentiality laws.

When you applied for coverage, you also authorized us to share records of your health when needed to administer your coverage.

We may share your records with:
- medical reviewers and consultants
- a utilization review board or entity
- any other health benefit plan with which you have coverage
- any other insurance company with which you have coverage

We respect your privacy, and have policies and procedures designed to safeguard confidential information we receive from providers.

If you’d like a summary of our policy and procedures, feel free to call us at the toll-free Customer Service number on your membership card.
Your benefits were designed with you and your family in mind. Prenatal care, well-child care, immunizations, periodic health assessments and eye and ear screenings are a part of your coverage. Other covered preventive health services include family planning counseling and services and health education programs.

**Women's Health Needs**

Women's annual exams are very important for good health. Your plan allows you to go directly to a contracting gynecologist without a referral from your PCP for your annual exam. Please refer to your Member Handbook for details of your plan.

Because of the importance of early detection, regular mammograms are also part of your BlueCare coverage. Mammograms are covered based on the following schedule:

- A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
- A mammogram every two years for any woman who is 40 years of age or older, but younger than 50 years of age, or more often based on a physician’s recommendation.
- A mammogram every year for any woman who is 50 years of age or older.
- A mammogram every year based on a physician’s recommendation for any woman who is at risk for breast cancer because of personal or family history.

Pregnancy testing is also covered by your plan. Any other exams or care you may need will be coordinated by your PCP.

**Maternity Care**

Your health care coverage plan is designed to take care of both routine and difficult pregnancies.

If you become pregnant, our Healthy Addition program provides prenatal counseling and education to help expectant mothers have healthier, full-term pregnancies to reduce the number of premature births.

High-risk cases that are identified are monitored to reduce the potential for expensive neonatal care that results from many problem pregnancies. Healthy Addition helps more women deliver healthy babies with fewer problems and complications.

For information about Healthy Addition, call 1-800-955-7635 and press 6 after the prompts.

**Just for Kids**

Health Options takes care of your children’s health care coverage needs from the moment of birth.

Your newborn will have a PCP that you choose from among our contracting providers. The PCP you choose will coordinate all of your child’s care.

Because growing up isn’t always easy, it helps to have a health care coverage plan for routine developmental care and checkups.

If potential problems are identified, your child’s PCP will counsel you regarding choices, so you’ll have the information you need to make decisions about your child’s continuing medical care or treatment.

**Your Family Members are Covered**

When you enroll, your family members may also be eligible to join. For example, family members eligible to enroll in BlueCare include:

- Your spouse
- Your children, stepchildren, legally adopted children, or children for whom you are a legal guardian. Note: Foster children may or may not be covered. Please refer to your Member Handbook for more details.

Your spouse and dependents may enroll:

- when you or your dependents are first eligible for BlueCare,
- during a subsequent open enrollment period, or
- during a special enrollment period.

Please refer to your Member Handbook for details about enrollment.
A Brief Description of Covered Services

Not all health care services and supplies which may be covered under your BlueCare plan are listed below.

Please check your Member Handbook for a complete list and details of covered services.

Hospital Care
Inpatient or outpatient hospital services such as room and board in a semi-private room, intensive care units, operating and recovery or emergency rooms, drugs and medicines, intravenous solutions, casts, anesthetics, transfusion supplies, and chemotherapy.

Physician Care
Physician services such as doctor visits when you are an inpatient, your outpatient office visits, surgical procedures, diagnostic services, and consultations.

Ambulatory Surgical Center Care
Ambulatory surgical center care such as use of operating and recovery rooms, oxygen, drugs and medicines, and other supplies or services.

Preventive Health Services
Preventive health services may include: periodic health assessments, instruction in personal health care measures, immunizations and inoculations, eye and ear screenings, family planning counseling and services, health education programs, and one annual gynecological examination per calendar year.

Ambulance Services
Ambulance transportation to the nearest medical facility which can provide required emergency services and care is a covered service if the use of an ambulance is medically necessary. All other ambulance or transportation services must be authorized by Health Options or ordered by your PCP.

Maternity Care
Prenatal, delivery and postnatal care.

Newborn Care
Newborn assessment and coverage for injury or sickness, including the care or treatment of birth abnormalities and prematurity.

Please Note: Coverage for the newborn child of a dependent will automatically terminate 18 months after the date of birth.

Well-Child Care
Up to the child’s 17th birthday, he or she may receive periodic examinations, immunizations, and lab tests normally performed for a well-child.

Accidental Dental Care
Dental care provided as a result of an accident which damaged sound natural teeth.

Prescription Drugs
If your employer purchased a prescription drug endorsement, drugs that are prescribed by a physician and dispensed by a pharmacist may be covered. Your prescription coverage may or may not be subject to a Preferred Medication List (PML). The PML is simply a list of medications that have been selected and reviewed by a panel of doctors and pharmacists for coverage by Health Options. The prescription drug endorsement included with your Member Handbook will give you information about your prescription drug program.

Other Covered Services
The following are also covered. Always refer to your Member Handbook for details and any limitations on services covered by your BlueCare plan.

• Skilled nursing facility care
• Home health care
• Prosthetic and orthotic devices
• Durable medical equipment
• Short-term rehabilitation services
• Diabetes treatment services
• Osteoporosis screening

Exclusions
Please refer to your Member Handbook for the specific exclusions related to your coverage.

• Any service not listed in the covered services section or in any endorsement
• Any service that has not been authorized by the member’s PCP except in cases of emergency as described previously
• Any services or supplies that are not medically necessary
• Custodial, domiciliary, convalescent, and rest care
• Personal comfort items, services, and supplies
• Cosmetic surgery that is not medically necessary
• Dental care
• Vision care
• Hearing aids
• Complementary and alternative healing methods
• Prescription drugs (unless your employer purchased a prescription drug endorsement)
• Experimental or investigational treatment
Working to Control Health Care Costs
We know how hard you work to provide for your family. At Health Options, we work just as hard to make sure your family’s health care coverage remains affordable. Together we can work to control the increasing cost of health care coverage and medical care.

**Coordination of Benefits**

If you are covered by another group plan or any kind of insurance that also provides health care benefits, please let Health Options know. When applicable, this allows us to coordinate your health care benefits with the other insurance company and possibly help minimize your out-of-pocket expenses.

**Subrogation**

If you are injured or become ill due to another person’s intentional act or negligence, the person responsible for your injury or illness should pay for your medical care. If you recover money from another person to compensate you for your damages, Health Options should be paid back for payments made on your behalf. This is called subrogation. You must contact Health Options with details of your accident or sickness and cooperate with Health Options.

**Case Management**

This program may be made available to you by Health Options, in its sole discretion, if you have a catastrophic or chronic condition. Under this voluntary program, Health Options may elect (but is not required) to offer alternative benefits or payment for cost-effective health care services. These alternative benefits or payments may be made available by Health Options on a case-by-case basis if you meet Health Options’ case management program criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which you, or someone representing you who is acceptable to Health Options, and your doctor agree to in writing. The fact that Health Options offers to provide any alternative benefits or payments under this program to you does not mean that Health Options is obligated to continue to provide such benefits or payments or to provide them to you or another person in the future. For detailed information, please refer to your Member Handbook, its terms prevail.
Members’ Rights and Responsibilities

You Have the Right:

1. To be given information about Health Options, its coverage and benefits, contracting providers and practitioners, and members’ rights and responsibilities.

2. To get health care from providers who meet Blue Cross and Blue Shield of Florida and Health Options’ credentialing standards and who contract with Health Options.

3. To participate in major decisions about your health care with your providers.

4. To have a frank discussion with your provider about the best treatment options for you no matter what the cost of the treatment or your benefit coverage.

5. To be treated with courtesy, respect, and concern for your dignity and privacy by providers and other patients.

6. To appeal unfavorable medical or administrative decisions by following established appeal or grievance procedures.

7. To refuse treatment if you choose to accept the responsibility and consequences of such a decision.

8. To have access to your medical records.

9. To call or write to us any time with helpful comments, questions and observations whether concerning something you like about our plan or something you feel is a problem area. Please call the number or write to us at the address on your membership card.

What Happens if Your BlueCare Coverage Ends

The following are reasons why BlueCare health care coverage may end:

• You are no longer a full-time employee
• You no longer meet each of the full-time employee requirements
• You leave your present employer
• Your employer no longer offers Health Options’ health care coverage
• Premiums or copayments are not paid
• You move away from the Health Options service area
• You knowingly commit fraud, make a misrepresentation, or give false information
• You are disruptive, unruly, abusive, or uncooperative
• You willfully misuse your membership card

Please refer to your Member Handbook for detailed information.
You May Choose to Continue Coverage Under COBRA

If you lose your health care coverage, you may be able to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). There are certain events that qualify a person to continue coverage under COBRA. If a person qualifies, then he or she must choose continuation of their group coverage under COBRA within 60 days of the date of the qualifying event. Your employer is responsible for giving you information about COBRA.

Please refer to your Member Handbook for detailed information about events that qualify a person for coverage under COBRA.

Conversion Options

If your Health Options membership ends, you may qualify to change your BlueCare coverage to an individual plan unless you become covered under another group plan within 31 days after coverage ends. You won’t need a medical examination to qualify for the individual plan, and family members that qualify may get coverage on the same basis.

Health Options offers two conversion options. Conversion Option A covers medical, hospital, and other health care services. Conversion Option B covers other benefits such as prescription drugs.

To apply for continuous coverage, we must receive your application and any required premium within 63 days after your group membership ends. You may call Health Options to get forms if you need to apply for a conversion option.
Advance Directives

At Health Options, we always want your coverage to meet your changing health needs. However, there are a few special circumstances in which you may want to communicate your wishes in advance, using an Advance Directive. An Advance Directive is a witnessed oral or written statement made while you are still of sound mind that gives your wishes for medical care. An Advance Directive includes your wishes as to whether life-prolonging procedures should be applied, whether to apply for Medicare, Medicaid or other health benefits, and with whom the health care provider should consult in making treatment decisions. The following is an overview only. Please refer to your Member Handbook for more information. There are three types of Advance Directive documents that are used most often in Florida: a Living Will, a Health Care Surrogate Designation, and a Durable Power of Attorney for Health Care. A general description of each follows:

Living Will
A Living Will is a document that explains your wishes as to whether life-prolonging procedures should be given, not given, or stopped if you are suffering from a terminal condition and are not able to express your own wishes.

Health Care Surrogate Designation
This Advance Directive gives authority to an appointed person of your choice, called a surrogate, to make health care decisions for you according to your wishes. The surrogate can make decisions only if you are not able to do so on your own. If it is necessary for the surrogate to make health care decisions for you, these decisions must be those that you would want, or make, if you were able to do so yourself.

There are some health care decisions that a surrogate cannot make, by law, on your behalf, such as agreeing that you have an abortion, or agreeing to electroshock therapy. This document must be specific as to what limits apply to your surrogate’s power to make health care decisions on your behalf.

Durable Power of Attorney for Health Care
This Advance Directive documents the person you appoint to be your attorney-in-fact to arrange and to agree to medical, therapeutic, and surgical procedures for you if you are not able to do so for yourself.

You Have a Choice Whether to Have an Advance Directive
You are not required to have an Advance Directive. However, if you choose not to have one, Florida law says the following persons can make decisions on behalf of a patient who is not able to do so. They are listed below in order of priority, based on this law:

- a legal guardian
- a spouse
- an adult child or children
- a parent
- sister(s) and/or brother(s)
- an adult relative who is familiar with your activities, health, and religious beliefs
- a close friend, who is an adult, familiar with your activities, health and religious beliefs

Deciding to have an Advance Directive is an important and complex decision. It may be helpful for you to discuss Advance Directives with your spouse, family, friends, religious or spiritual advisor or attorney. The goal for making an Advance Directive should be for a person to clearly state his or her wishes to ensure the health care facility, physician and whoever else will be faced with carrying out those wishes know what you would want. We also recommend that you give a copy of your Advance Directive to your PCP and family members.

If you believe your provider has not complied with your Advance Directive, you or your representative may file a complaint by writing to the following address:

Agency for Health Care Administration, Bureau of Managed Care
2727 Mahan Drive
Bldg. 1, Room 311
Tallahassee, FL 32308
Terms to Understand

Here are some terms that will help you understand your health care coverage.

**Case Management** is a mutually agreed upon arrangement for the payment or coverage of approved health care services on a case-by-case basis.

**Contracting Provider** means any health care provider who provides health care services or supplies to you and has an agreement with Health Options to participate in the HMO network at the time the services or supplies are rendered.

**Coordination of Benefits** is a method by which Health Options attempts to avoid duplicate payment for expenses covered under more than one health insurance plan or health care policy.

**Copayment** means the pre-established dollar amount you pay for covered services.

**Coverage Access Rules** are rules for getting health care coverage and benefits through Health Options. They explain the role of Health Options and the PCP, how to get specialty care, and what to do if emergency services and care are needed. Please refer to your Member Handbook for details on the coverage access rules.

**Credentialing** means the process used to verify that a provider is properly licensed and has obtained the appropriate professional, technical or educational certifications.

**Experimental or Investigational** generally means any service or procedure that has not, in the opinion of Health Options, been proven to be safe and effective.

**Non-Contracting Provider** means any health care provider with whom Health Options does not have an agreement to participate in its HMO network at the time a service or supply is rendered. If you go to a non-contracting provider, you may be balance billed.

**Medically Necessary or Medical Necessity** means that for coverage and payment purposes, a medical service or supply is, in the opinion of Health Options, required for the identification, treatment, or management of a Condition.

**Primary Care Physician (PCP)** is a doctor who has agreed with Health Options to act as a Primary Care Physician and who generally coordinates or directly provides most of your medical care. Your PCP must participate with Health Options as a PCP.

**Premium** is the amount you are required to pay in order to have health care coverage.

**Service Area** is the geographic area described in your Member Handbook.
Questions and Answers

Q. What if I have an accident and am taken to a non-participating hospital?
A. In an emergency, you are covered for all necessary care administered by any provider. You, or a member of your family, must contact your PCP or Health Options after receipt of such emergency services and care to arrange for follow-up care.

Q. What happens if I have an emergency?
A. Go to the nearest hospital or call 911. Your BlueCare benefits extend worldwide in an emergency. It is important for you, or a member of your family, to contact your PCP or Health Options as soon as possible after receipt of emergency services and care, to arrange for follow-up care. If you receive a bill, send it to Health Options.

Q. What if I require the services of a specialist and/or consultant?
A. As a Health Options member you have access to specialists and/or consultants in every major field of medicine, through referral by your PCP.

Q. What happens if I have been seeing a health care provider who is not a Health Options participant?
A. You will not be covered if you see a non-contracting health care provider without a referral from your PCP. Health Options is associated with specialists and/or consultants in every major field of medicine. Your PCP will arrange for your care to be continued with a specialist and/or a consultant, if necessary.

Q. What should I do if I become ill in the middle of the night?
A. Call your PCP and discuss the nature of your condition. Your PCP will then advise you about when and where to seek treatment. In an emergency, call 911.

Q. If I have single member coverage and marry or have a child, may I add a dependent to my coverage?
A. Newly acquired dependents may be added without waiting for open enrollment, provided application is made according to the requirements described. You must add newly acquired dependents to your coverage within 30 days or during the next Open Enrollment Period. Please see your Member Handbook for complete information.

Q. May I convert to individual coverage if I leave my group employer?
A. If your coverage ends as a result of leaving the group, you may convert to individual coverage without regard to health status within 63 days after receipt of notice of termination of coverage under the group.

Q. Will I have to fill out forms for any insurance and pay deductibles and the customary fee for office visits?
A. With Health Options, there are no claim forms to fill out or deductibles to meet when you receive care from your PCP. You may see your PCP whenever necessary, but may be required to make a copayment at the time services are rendered.

Q. What if I have a non-medical question about my coverage?
A. Call our Customer Service number on your membership card during regular business hours.

Remember, care must be received from, or coordinated by, your Primary Care Physician.