

# For Your Information



**BlueCross BlueShield  
of Florida**  
**Health Options®**

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

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# FOR YOUR INFORMATION

## Introduction

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

This brochure contains information about your HMO, Health Options, which is a wholly owned subsidiary of Blue Cross and Blue Shield of Florida, Inc.—a leader in health care coverage for more than 60 years. Health Options has been accredited by the National Committee for Quality Assurance (NCQA®), an independent, nonprofit organization located in Washington, D.C., that assesses the quality of managed care organizations. 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 in South Florida has received Commendable accreditation for their Medicare HMO products. In 2006, Health Options will undergo a statewide survey.

Please take a few minutes now to read the following pages. Included is information about specific Health Options policies that are designed to protect you and your family and that are part of the standards used by NCQA when evaluating a health plan for accreditation. This information is available to you at any time upon your request.

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## The Role of Your Primary Care Physician

Your medical care begins with your primary care physician (PCP). Your PCP coordinates your health care and ensures that you are referred to contracting specialists or admitted to contracting hospitals when such care is needed.

**Note: To receive benefits offered through Health Options, arrange all routine and elective medical care with your PCP.**

## Selecting a PCP

Select a doctor from our network of primary care physicians. Visit our website at [www.bcbsfl.com](http://www.bcbsfl.com) to view or print a selection from our online provider directory. Our online provider directory gives you the most up-to-date information about our providers, including their specialties, phone numbers, addresses and any age limits on patients. You also can call Customer Service at **(877) 352-2583** for a copy of the provider directory.

If you wish to check a provider's education, licensing credentials or board certification, call the Department of Health at **(850) 488-0595**, or link to their website through our online provider directory. For the hearing- and speech-impaired who use a telecommunication device, dial Florida Relay, **711**.

Should you wish to file a complaint against a provider or check the status of a disciplinary action against a provider, call the Agency for Health Care Administration Information Center at **(888) 419-3456** (TTY users, dial 711).

To change your PCP, call Customer Service at the number on your ID card. When Customer Service confirms your PCP change, please note the date your new PCP becomes effective and continue to work with your current PCP until that date.

## 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 also should bring any medications you currently are taking to your new 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.

## Referrals to Specialists and Hospitals

There may be times when your PCP will need to refer you to a contracting specialist or hospital for care. In these instances, your PCP will contact Health Options to obtain confirmation for the referral or authorization before you receive care from a contracting specialist or facility.

To ensure coverage, please do not contact a specialist directly unless the provider is an in-network direct access specialist (see below). Routine or urgent care received prior to authorization by the PCP will not be covered. If you have questions regarding the services to be rendered, the number of visits authorized or the time frame for these services, please ask your PCP to explain.

## Direct Access to Specialty Care

Visit our online provider directory at [www.bcbsfl.com](http://www.bcbsfl.com) for a list of contracting specialists, or call Health Options. Please identify yourself as a Health Options member when making your appointment.

- **Chiropractors**—For your convenience, you may use the services of a contracting chiropractor within the service area without a referral from your PCP.

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- **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.
  - **Gynecological Services**—Direct-access guidelines for contracting gynecologists vary somewhat from plan to plan. However, throughout Florida, women may visit a contracting gynecologist within the service area for an annual routine examination without being referred by their PCP.
  - **Mental Health/Behavioral Health**—Health Options provides mental health services to its eligible members through an arrangement with MHNNet. MHNNet has a system of mental health professionals, including psychiatrists, psychologists and licensed therapists, providing both inpatient and outpatient care. To arrange an appointment, please call your primary care physician or call MHNNet directly at **(800) 835-2094**, 24 hours a day, seven days a week. For the hearing- and speech-impaired who use a telecommunication device, dial Florida Relay, **711**. For copayment and benefit information, please refer to your copayment schedule and Member Handbook.
  - **Podiatrists**—You may use the services of a contracting podiatrist within the service area without a referral from your PCP. Please identify yourself as a Health Options member when making your appointment.

## Utilization Management

Utilization Management (UM) is part of the Blue Cross and Blue Shield of Florida/Health Options benefits management process and currently includes activities such as authorizations, concurrent review, discharge planning, retrospective review and the Case Management Program.

The authorization process is designed to review and record your inpatient hospital admissions and other services (i.e., outpatient services, referrals) for medical appropriateness and coverage under your contract.

The concurrent review process is designed so nurses/concurrent review coordinators can evaluate and monitor your inpatient admission(s) throughout your service episode.

Discharge planning is designed to provide your timely and appropriate discharge from the acute-care hospital setting to your home or an appropriate alternate facility.

Retrospective review is an evaluation of medical care that has already been received.

Case Management is a voluntary program, which may be made available to you by Health Options if you have a catastrophic or chronic condition.

## When Your Doctor's Office Is Closed—After-Hours Medical Care

You may need medical care when your PCP's office is closed. **In the event of a medical emergency, always go to the nearest hospital 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 then will call your PCP, who will call you back and give you instructions.

## Emergency Services and Care

Health Options provides you with emergency medical coverage anywhere in the world. Should you require emergency services and care as a result of an emergency medical condition, you will be required to pay only the copayment, if any, listed in your Schedule of Copayments or current ID card. When seeking emergency services and care, the determination as to whether an emergency medical condition exists will be made for the purposes of treatment by the attending physician in the emergency room of the hospital, or any appropriately licensed professional hospital personnel working under the supervision of the hospital physician, or

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otherwise as determined by law. **Follow-up care must be received, prescribed, directed or authorized by your primary care physician.** 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.

An emergency medical condition is one where failure to obtain immediate medical attention could result in any one of the following:

- Serious jeopardy to the health of a patient, including a pregnant woman or a fetus
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

If you have any questions, please feel free to call our Customer Service Department at the number on your ID card.

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.

## 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 ID 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 ID card. Please refer to your Schedule of Copayments for the emergency services and care copayment.

**Non-emergency or non-urgent services, except out-of-area renal dialysis, rendered outside of the service area must be authorized in advance by Health Options in order to be covered for payment. You may be financially liable for out-of-area or out-of-plan services that are not preauthorized.**

## Filing Claims

Always be sure to show your membership card when you receive health care services. 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. If you receive emergency medical services and care from a provider who does not contract with Health Options, you may need to send your bill to Health Options at the address on your ID card. Please call Customer Service first to determine whether or not a claim has been filed.

## Customer Service

Call toll free, **(877) 352-2583**, Monday–Thursday, 8 a.m.–9 p.m., and Friday, 9 a.m.–9 p.m., Eastern time. For the hearing- and speech-impaired who use telecommunication devices, dial **711** for the Florida Relay Service.

## About Confidentiality

Health Options respects your privacy and has policies and procedures designed to safeguard your personal information, in all forms—spoken, written and electronic. You already have been provided with a copy of our Notice of Privacy Practices. If you wish to view or obtain another copy, you may visit us at [www.bcbsfl.com](http://www.bcbsfl.com), or call us at the number listed on your ID card.

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## Care Without Discrimination

Members have a right to expect that health care providers who contract with Health Options' network will not discriminate against members in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.

## Translation Services

Health Options' policy is to provide prompt customer service to all of our members. We employ many Spanish-speaking customer service representatives and internal service associates to serve the large number of Floridians who speak Spanish. We also employ many multilingual people to meet the needs of members who speak other languages.

Non-English-speaking members can obtain help at any Health Options office. We have multilingual staff available throughout the company. There is no charge when we provide service in a language other than English.

When a non-English-speaking member calls Health Options, we ask for the member's language preference. An internal service associate assists the member in that language whenever the service capability exists. Sometimes a member cannot communicate a language preference. Other times, we are unable to serve the member in the language of preference. In those cases, we ask the member to have an English-speaking friend or relative help. The member and the English-speaking friend or relative can call Health Options at their convenience. We will respond to the member's inquiry at that time.

If you have any further questions concerning this matter or need additional assistance, please feel free to contact our customer service representatives toll free at **(877) 352-2583**, Monday–Thursday, 8 a.m.–9 p.m., and Friday, 9 a.m.–9 p.m., Eastern time. For the hearing- and speech-impaired who use telecommunication devices, dial **711** for the Florida Relay Service.

## Continually Looking at New Technology

The types of treatments, devices and drugs covered by your HMO plan are extensive. In light of the rapid changes in medical technology, it is important to continually look at new medical advances 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 regulatory agency, such as the U.S. Food and Drug Administration
- 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 are consulted. These include published clinical studies from respected scientific journals and physicians from various medical specialty organizations.

Because we strive to cover only treatments that have been proven to be safe and effective for a particular disease or condition, Health Options does not cover experimental or investigational services. Also, we try to determine if any new medical technology is superior to treatments already in use.

## Policy on Financial Incentives

Health Options has the following policy on financial incentives. It is designed to assist practitioners, providers, employees and supervisors involved in, or who supervise those involved in, making coverage and benefit utilization management and/or utilization review decisions.

Utilization management and/or utilization review decision-making is based only on:

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- The factors set forth in Health Options' definition of medical necessity (for coverage and payment purposes) that are part of our medical policy guidelines then in effect; and
  - Whether coverage and benefits exist under a particular contract, policy or certificate of coverage.

Health Options is solely responsible for determining whether expenses incurred (or to be incurred) or medical care are (or would be) covered or paid under a contract or policy. In fulfilling this responsibility, Health Options shall not be deemed to participate in or override the medical decisions of any Health Options member's practitioner or provider.

Health Options does not specifically reward practitioners or other individuals conducting utilization management and/or utilization review for issuing denials of coverage or benefits. Financial incentives for utilization management and/or utilization review decision makers do not encourage decisions that result in underutilization. The intent is to minimize coverage and payment for unnecessary or inappropriate health care services, reduce waste in the application of medical resources, and to minimize inefficiencies that may lead to the artificial inflation of health care costs.

## Make Your Wishes Known

If you are incapacitated and cannot make decisions about your medical care, your wishes can be known if you have an advance directive. It assures that your doctor, the health care facility and anyone else faced with making a decision about your medical treatment know what you would want.

An advance directive is a witnessed oral or written statement that indicates your choices and preferences with respect to medical care. It preserves your right to accept or decline medical care even if you cannot speak for yourself. Four types commonly used and recognized by the state of Florida include:

- A living will
- A health care surrogate designation (a person who has limited decision-making powers)
- A durable power of attorney for health care (a person who becomes an attorney-in-fact and can make all decisions regarding care)
- A do-not-resuscitate order

You may obtain information regarding advance directives from the following sources:

- Your physician or health care provider
- Your local hospital or skilled nursing facility
- The Agency for Health Care Administration (AHCA) website at [www.MyFlorida.com](http://www.MyFlorida.com) (contains downloadable information, forms and a wallet card)

If you have complaints concerning noncompliance with the advance directive requirements, you may contact AHCA at:

Agency for Health Care Administration  
Subscriber Assistance Program  
2727 Mahan Drive  
Bldg.1, Rm. 339  
Tallahassee, FL 32308  
**(888) 419-3456**  
(TTY users, dial **711**)

Provide a copy of your advance directive to family members and all your physicians so that it becomes part of your medical record. For more information, contact a Health Options customer service representative, physician or local hospital.

## Members' Rights & Responsibilities

Health Options, Inc., Blue Cross and Blue Shield of Florida's HMO subsidiary, is committed to offering quality health care coverage, as well as maintaining the dignity and integrity of our members. Recognizing that service providers are independent contractors and not the agents of Health Options, we have adopted the following member rights and responsibilities.

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## Rights

As a member, you or your representative has the right:

1. To be provided with the following information about Health Options:
  - Its benefits and costs and the choice of independent contracting plan providers and practitioners providing care.
  - An explanation about any bills you may receive from non-covered services.
  - Its members' rights and responsibilities.
2. To access medical care and treatment from providers, including your primary care physician (PCP) and referrals when medically necessary, who have met the credentialing standards of Health Options.
3. To expect health care providers who contract with Health Options to:
  - Discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
  - Permit you to participate in the major decisions about your health care and treatment options, consistent with legal, ethical and relevant patient-provider relationship requirements.
  - Advise whether your medical care or treatment is part of a research experiment, and to give you the opportunity to refuse any experimental treatments.
  - Inform you about any medications you are told to take, how to take them and their possible side effects.
4. To expect courteous service from Health Options and considerate care from contracting providers with respect and concern for your dignity and privacy.
5. To expect that health care providers who contract with Health Options' networks not discriminate against members in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.
6. To accessible services, both clinical and non-clinical, regardless of whether a member has limited English proficiency or reading skills, has diverse cultural and ethnic backgrounds, or has a physical or mental disability.
7. To voice your complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in your Evidence of Coverage or other procedures adopted by Health Options for such purposes.
8. To inform contracting providers that you refuse treatment, and to expect to have such providers honor your decision if you choose to accept the responsibility and the consequences of such a decision. Members are encouraged, but not required:
  - To complete an advance directive, such as a living will, and provide it to your contracting plan providers.
  - To have someone help you make decisions, or to give another person the legal responsibility to make decisions, about medical care on your behalf.
9. To access your medical records and any information that pertains to them, and to have the confidentiality of these records maintained in accordance with applicable law and Health Options' rules. Written permission from you or your authorized representative shall be obtained before medical records can be made available to any person not directly involved with your care or responsible for making payments for the cost of such care.
10. To make recommendations regarding Health Options' members' rights and responsibilities policies. Please call the number or write to us at the address on your membership card.

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11. To request information on the following:
    - General coverage and comparative plan information
    - Utilization management procedures
    - Statistical data on Appeals and Grievances
    - The financial condition of Health Options
    - Summary of provider compensation arrangements that may affect the use of referrals and other services that you might need. (For this information, call the telephone number listed on your health plan ID card.)
  12. To receive emergency medical services when you, as a prudent layperson acting reasonably, would have believed that an emergency medical condition existed. Payment will not be withheld in cases when, acting reasonably, you seek emergency medical services.
  13. To receive urgently needed services when traveling outside the service area or in the service area when unusual or extenuating circumstances prevent you from obtaining care from your primary care physician.
  14. To receive out-of-area renal dialysis up to the original Medicare allowable amount.
  15. To receive a document called "Important Message From Medicare" from the hospital when you are hospitalized. This document explains your rights as a hospital patient.
  2. To be respectful of the rights, property, comfort, environment and privacy of other individuals and not be disruptive.
  3. To take responsibility for understanding your health problems and participate in developing mutually agreed upon treatment goals, as best as possible, then following the plans and instructions for care that you have agreed upon with your Health Options provider.
  4. To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
  5. To be financially responsible for any copayments or plan premiums, if applicable, and to provide current information concerning your enrollment status to any Health Options-affiliated provider.
  6. To follow established procedures for filing an appeal or grievance concerning medical or administrative decisions that you feel are in error.
  7. To request your medical records in accordance with Health Options rules and procedures and in accordance with applicable law.
  8. To review information regarding covered services, policies and procedures as stated in your Member Handbook or this agreement.

## Responsibilities

As a member, you have the responsibility:

1. To seek all non-emergency or non-urgent care, except out-of-area renal dialysis, through your assigned primary care physician (PCP), to obtain a referral from your PCP for specialist care when required, and to cooperate with all persons providing your care and treatment.

## Helping You Make Informed Decisions

In an effort to assist members in making informed decisions about their health care, Blue Cross and Blue Shield of Florida provides a link on its website to the Florida Agency for Health Care Administration (AHCA). The AHCA website provides physician and hospital information on a number of surgeries performed in a particular hospital, whether a physician has medical insurance and when a doctor graduated from school.

The AHCA website also provides a link to the Centers for Medicaid & Medicare Services Hospital Compare website, where consumers can compare the quality of care hospitals in their region provide for various medical conditions.

Go to our website, [www.bcbsfl.com](http://www.bcbsfl.com), click on "Provider Directory," then the tab marked "Helpful Information." Scroll down to "Health Resources" and click the link for Florida Health Stat.

## Report Card

A commitment to quality care and service is fundamental at Blue Cross and Blue Shield of Florida and our HMO subsidiary, Health Options. Members are our reason for being. To help us meet your expectations, we periodically conduct customer satisfaction surveys. We also analyze a number of indicators that relate to effectiveness and accessibility of care, as well as use of services, using the Health Plan Employer Data and Information Set (HEDIS®) established by the National Committee for Quality Assurance (NCQA). NCQA is an independent, nonprofit organization whose mission is to evaluate and report on the quality of the nation's managed care organizations.

The HEDIS scores identify opportunities for action. For example, last year we provided educational materials to members and providers on various topics; and we collaborated with physician groups to develop best practices. We have developed comprehensive disease management programs to help members with chronic conditions like diabetes and congestive heart failure better manage their health. The programs encourage cooperation and communication between Health Options, the physician and member to gain the best possible health care experience for our members.

See the accompanying chart for highlights of the latest findings, showing the rate of members in South Florida who received certain screenings and other care compared with the national average.

## 2004 HEDIS Effectiveness of Care Measures

Measure	Health Options*	National Average
Breast Cancer Screening	73%	73%
Comprehensive Diabetes Care		
– Lipid Profile	97%	92%
– HbA1c Testing	91%	88%
– Dilated Retinal Exam	52%	65%
Beta Blocker Treatment After Heart Attack	99%	93%
Cholesterol Screening After Acute Cardiovascular Event	91%	82%

HEDIS® is a registered trademark of NCQA.

Source: NCQA's 2005 *State of Health Care Quality*

\*Does not include Commercial HMO members

## Member Satisfaction

The Consumer Assessment of Health Plan Survey (CAHPS®) results report member satisfaction with services provided by their doctors and health plans during 2004. The annual survey covers aspects such as the ability to get care quickly, the timeliness and accuracy of claims processing, and the ease of getting and understanding information from your health plan. The accompanying chart (page 11) compares the responses of Health Options Medicare HMO members with the national average.

We also monitor members' verbal and written complaints to assess customer needs and expectations. Providing a snapshot of member concerns, this enables Health Options to address member issues one-on-one, as well as develop initiatives to improve service to all members. The top three major issues last year centered on dissatisfaction with non-covered benefits, allegations of balance billing and Health Options processes concerning networks and authorizations.

## 2004 Member Satisfaction Measures

Measure	Health Options*	National Average**
Courteous and Helpful Office Staff	94%	95%
Health Plan Customer Service	71%	79%
Getting Care Quickly	79%	84%
Getting Needed Care	83%	85%
How Well Doctors Communicate	91%	93%
Overall Rating of Health Care Received	82%	84%
Overall Rating of Health Plan	61%	75%
Rating of Personal Doctor	85%	84%
Rating of Specialist	79%	82%

\*Does not include Commercial HMO members

\*\*Source: 2005 Medicare CAHPS®

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

### Improvement Initiatives

In addition to quality of care initiatives, Health Options monitors the quality of the service that is provided to our members. While we hope that every service experience is a positive one, we continually seek to improve service quality for our members. This past year we have focused improvement initiatives on timeliness of and access to service as follows:

- Customer Service—Shortening the hold time before a member speaks to a customer service representative
- Member Inquiries—Implemented a Speech Recognition System enabling members to access information about benefits and claims by phone 24/7
- Prior Authorizations—Improving timeliness of care by reducing the prior authorization requirements
- Communication—Improving communication between members and physicians

If you would like to provide input or make recommendations to our Quality Programs, please call the number or write to us at the address on your membership card.

## Mental Health Services

Health Options' mental health service network is administered by Mental Health Network (MHNet). MHNet follows NCOA standards regarding your ability to reach a provider easily and to get an appointment in a timely manner.

They also evaluate quality improvement and utilization management activities and conduct member satisfaction surveys.

MHNet's Quality Improvement Committee continues to address areas related to overall member satisfaction. Upon request, MHNet will make available to its enrollees information about its Quality Improvement Program, including a description of the program and a progress report on meeting their goals. To request a copy from MHNet, call **(800) 835-2094**. For TTY, call the Florida Relay Service at **711**.



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