

# 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. In its 2006 review, Health Options received Excellent accreditation for their commercial HMO products.

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.



**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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## 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 admitted to contracting hospitals when such care is needed. **Note: You no longer need to receive a referral from your PCP when seeking care from a specialist who participates in the Health Options network. However, to receive benefits for all other care, arrange services through 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. When enrolling, remember to list each family member's choice of PCP.

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.

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**.

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.

If you seek care from any other in-network physician who is not your designated PCP (i.e., listed on your ID card), you will be responsible for the specialist copayment. This includes any family practitioner, internist or other primary care type of physician.

## 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 Hospitals

There may be times when your PCP will need to refer you to a contracted hospital or other facility for care. In these instances, your PCP will contact Health Options to obtain confirmation that these services have been authorized and approved before you receive care from the facility.

To ensure coverage, please validate with Health Options or your PCP that an approved authorization has been obtained. Care at any facility, other than an emergency room, received prior to authorization will not be covered. If you have questions regarding the services to be rendered, the number of visits authorized, the time frame for these services or the effective date of authorization for these services, please ask your PCP to explain.

## 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 copayment and benefit information, please refer to your copayment schedule and Member Handbook.

## 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 (e.g., outpatient services, office surgery, self-injectable medications, etc.) 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 the medical appropriateness of care/services that you already 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.

For questions related to Utilization Management/Case Management, please call Customer Service at the number on your ID card.

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## 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 otherwise as determined by law. Follow-up care does not require authorization if it is provided by your primary care physician or by contracted specialists in Florida. However, if you are out of state or require follow-up care from a facility or non-contracted provider, you must contact your PCP to have your follow-up care authorized appropriately. If follow-up care is not coordinated by your PCP or a Health Options-contracted specialist, 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.

## BlueCard®

When you are away from home on short trips (less than 90 days), the BlueCard Program gives you access to doctors and hospitals who participate in the BlueCard network almost everywhere, giving you the peace of mind that you'll have access to the care you need. If you need care while away from home for less than 90 consecutive days, follow these easy steps:

1. Always carry your current ID card for easy reference and access to service.
2. In an emergency, go directly to the nearest hospital.
3. Call your PCP or HMO for prior authorization and/or precertification. **Non-emergency services 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 any out-of-area or out-of-plan services that are not preauthorized.**
4. To find names and addresses of nearby contracting doctors and hospitals, visit the BlueCard Doctor and Hospital Finder website at [www.bcbs.com](http://www.bcbs.com), or call BlueCard Access at **(800) 810-BLUE**.
5. When you arrive at the contracting doctor's office or hospital, simply present your ID card.

After you receive care, you should not have to complete any claim forms, nor should you have to pay for medical services other than your usual out-of-pocket expenses.

## Away From Home Care®

Away From Home Care coverage puts you in touch with HMO care from qualified physicians in nearly every state in the country. This coverage supplements Health Options out-of-area benefits through the country's largest HMO network. The Blue Cross and Blue Shield network of HMOs offers health care coverage in more than 250 major cities across the country.

## Guest Membership

For anyone away from home for at least 90 days (and up to six months for the subscriber), we offer Guest Membership at an affiliated HMO near your travel destination. This is beneficial for extended out-of-town business and for families living apart.

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## What to Do for Guest Membership

You may call the Customer Service number listed on your ID card to verify if your travel location is available for coverage. If available, an Away From Home Care enrollment application will be forwarded to you for completion. Once you arrive at your new travel destination, you will receive information from the host HMO on how to access medical coverage.

**Note:** The above services may not be available to all Blue Cross and Blue Shield of Florida/Health Options group plans or members at this time.

## 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.

## 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 a customer service representative toll free at **(877) 352-2583**, Monday–Thursday, 8 a.m.–9 p.m., 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.

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## Financial Incentives Policy

Health Options, Inc. 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:

- 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 minimize inefficiencies that may lead to the artificial inflation of health care costs.

## Complaint and Grievance Process

Health Options has a complaint and grievance process in place for you so that any concerns you may have about your health care coverage can be addressed. These concerns may involve coverage, benefit, payment decisions or quality of care, as well as network or provider issues.

Oral complaints will be accepted either by telephone or in person. You may either call the Health Options Customer Service area at the telephone number on the back of your membership card or go to your local Health Options office in person (the address is in your BlueCare Member Handbook under the Complaint and Grievance section) to file your oral complaint. We are committed to resolving your complaint within a reasonable amount of time.

If you don't agree with our response to your oral complaint, or if you prefer to file your complaint in writing, you may file a written grievance to:

Tampa/Jacksonville  
Health Options, Inc.  
4800 Deerwood Campus Parkway  
Building 400, 1st Floor  
Jacksonville, FL 32246  
Attn.: Grievances and Appeals

Orlando/Miami  
Health Options, Inc.  
8400 N.W. 33rd St.  
Miami, FL 33122  
Attn.: Grievances and Appeals

Grievances relating to the denial of coverage by Health Options based on medical necessity must be filed within 30 calendar days from the date you receive the denial to be reviewed according to state guidelines by the Internal Review Panel, which consists of a majority of physicians. For all other grievances, you have one year from the date of incident. Health Options will complete the review of your grievance and notify you of the decision within 15 calendar days from the receipt of your grievance for a preservice denial and 30 calendar days for all other grievances.

If you are not satisfied with the decision from Health Options, you may appeal to the Health Options Board of Directors Grievance Committee. You may complete a Health Options Grievance form or write a letter detailing your concern. The Health Options Board of Directors Grievance Committee will review your grievance and notify you of the decision within 15 calendar days of receipt for a preservice denial and 30 calendar days for all other grievances. For potential quality of clinical care issues, all levels of the grievance process must be completed within 60 calendar days. 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 Subscriber Assistance Panel within 365 days of receiving the Health Options corporate office decision. There is no charge for this service. In addition you may send your grievance in writing to the Subscriber Assistance Panel if you are not satisfied with your decision regarding an expedited grievance within 365 days of receiving Health Options' decision. You may contact them toll free at **(888) 419-3456**, or you may mail your grievance to:

Subscriber Assistance Program  
2727 Mahan Drive  
Building 1, Room 339  
Tallahassee, FL 32308

You and your plan may have other voluntary alternative dispute-resolution options, such as mediation. Contact your local U.S. Department of Labor office and/or the state regulatory agency listed above for information about what options may be available.

If you are a member of an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have a right to bring a civil action under Section 502(a) of ERISA if your claim is denied after all appeal steps required by your plan have been completed. Check with your group administrator or attorney to determine if ERISA applies to your group plan.

## 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 knows 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.

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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

Provide a copy of your advance directive to family members and all your physicians so that it becomes part of your medical record. We also recommend keeping a copy in the glove compartment of your car. For more information, contact your customer service representative, physician or local hospital. You also may obtain information from 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:

Agency for Health Care Administration  
Subscriber Assistance Program  
2727 Mahan Drive  
Building 1, Room 339  
Tallahassee, FL 32308  
**(888) 419-3456**

## 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 member rights and responsibilities below.

### Rights

1. To be provided with information about Health Options, our services, coverage and benefits, the contracting practitioners and providers delivering care, and members' rights and responsibilities.
2. To receive medical care and treatment from contracting providers who have met our credentialing standards.
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, consistent with legal, ethical and relevant patient-provider relationship requirements.

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 voice your complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in the Member Handbook or other procedures adopted by Health Options for such purposes.
6. 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.
7. To have access to your records and to have confidentiality of your medical records maintained in accordance with applicable law.
8. 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. You also may 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.

### Responsibilities

1. To seek all non-emergency care through your assigned PCP or a contracting physician and to cooperate with all persons providing your care and treatment.
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 and non-covered services, and to provide current information concerning your enrollment status to any Health Options-affiliated provider.
6. To follow established procedures for filing a 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 applicable law.
8. To follow the Coverage Access Rules established by Health Options.

## 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 variety of medical outcomes. It includes data such as the 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 Medicare & Medicaid 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.bcsf.com](http://www.bcsf.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, non-profit 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. In addition, we provide educational materials to members and providers on various topics; and we collaborate with physician groups to develop best practices. We have developed comprehensive disease management programs to help members with asthma, 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.

The accompanying chart highlights the latest findings, comparing the rate of Health Options' BlueCare members who received certain immunizations, screenings and other care with the national average.

HEDIS® is a registered trademark of NCQA.

### 2005 HEDIS Effectiveness of Care Measures\*

Measure	Health Options**	National Average
Adolescent Immunizations		
– MMR	60.3%	78.9%
– Hepatitis B	56.1%	72.5%
– VZV	53.6%	61.1%
Appropriate Testing for Children with Pharyngitis	67.3%	70.7%
Appropriate Treatment of Children with Upper Respiratory Infection	80.3%	82.8%
Asthma Medication Use Ages 18-56 (Av. %)	95.1%	89.9%
Beta Blocker After Heart Attack	97.0%	97.1%
Breast Cancer Screening Ages 52-69	71.0%	71.8%
Cervical Cancer Screening Ages 18-64	78.8%	82.3%
Childhood Immunization		
– DTP	85.6%	86.2%
– IPV	88.8%	90.3%
– MMR	93.2%	93.1%
– HiB	92.2%	92.9%
– Hepatitis B	89.1%	90.0%
– VZV	90.8%	90.0%
Comprehensive Diabetes Care Ages 18-75		
– Lipid Profile	95.6%	92.4%
– HbA1c Testing	94.7%	87.6%
– Dilated Retinal Exam	37.7%	54.7%
Controlling High Blood Pressure	71.5%	69.6%
Follow up After Hospitalization for Mental Illness within 7 Days	46.8%	56.0%
Timeliness of Prenatal Care	93.9%	92.7%
Postpartum Care	81.0%	82.0%

\* 2005 results reported in 2006

\*\* Source: NCQA's 2006 State of Managed Care Quality Report. Does not include Medicare 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 2005. 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 8) compares the responses of Health Options' BlueCare 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 and develop initiatives to improve service to all members. Major issues last year centered on customer service, authorization and timeliness and/or accuracy of claims payments.

### 2005 Member Satisfaction Measures\*

Measure	Health Options	National Average
Courteous Office Staff	90.1%	93.2%
Health Plan Customer Service	72.2%	71.2%
Claims Processing	91.6%	89.2%
Getting Care Quickly	73.7%	79.7%
Getting Needed Care	76.5%	80.2%
How Well Doctors Communicate	89.8%	92.1%
Overall Rating of Health Care Received	77.7%	78.0%
Overall Rating of Health Plan	67.3%	65.3%
Rating of Personal Doctor	77.7%	77.2%
Rating of Specialists	78.9%	78.2%

\*Source: 2006 CAHPS. Percentages equate to the sum of all positive and neutral responses. Does not include Medicare HMO members

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

## Improvement Initiatives

While we hope that every service experience is a positive one, we continuously seek to improve service quality for our members. This past year we have focused improvement initiatives on better access to health information and tools, as well as improving our cultural competency:

- **Member Self-Service**—Improved access to information by providing easy-to-use tools and services.
- **Cultural Competence**—Developed capabilities to better serve our multi-cultural communities, including language enhancements and culturally relevant health materials.
- **Care Coordination**—Care Coordination program implemented to help members navigate through the health care system and their contract benefits.
- **Customer Service**—New telephone menu developed to route the caller to the correct area the first time.

## Mental Health Services

The Health Options mental health service network is administered by Mental Health Network (MHNet). For specific information on these benefits, please refer to your member handbook and copayment schedule.

MHNet follows NCQA standards regarding your ability to reach a provider easily and to get an appointment in a timely manner. MHNet evaluates quality improvement and utilization management activities and conducts member satisfactory 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**.

# Preventive Care Guidelines

Working with your primary care physician to stay well is as important as getting treatment when you are sick. The following Preventive Care Guidelines, established over a period of four years by the United States Preventive Services Task Force, will help you and your doctor make sure that you get the tests, immunizations (shots) and guidance you need to stay healthy at different stages throughout your and your family members' lives.

We encourage you to talk to your primary care physician about these recommendations and ask questions if you don't understand something. This will help you get the answers you need to keep you healthy. Look at this guide often to make sure that you get the preventive care you need. Bring it with you every time you see a health care provider. It is a good idea to make appointments for preventive care checkups six weeks in advance.

## Birth to 10 years

<b>Screening</b>	<ul style="list-style-type: none"> <li>• Height and weight</li> <li>• Blood pressure</li> <li>• Anemias, PKU, thyroid (birth)</li> <li>• Vision screening</li> </ul>
<b>Health Guidance and Advice</b>	<p><b>Injury Prevention</b> In order to reduce the risk of serious injury, follow these suggestions:</p> <hr/> <p><b>Diet and Exercise</b> Eating the right foods and regular physical activity will benefit both mind and body.</p> <hr/> <p><b>Dental Health</b> Maintain good dental health in your family.</p> <hr/> <p><b>Substance Use</b> Keep your body healthy by following this guideline:</p>
<b>Immunizations</b>	<p><b>DTP</b> 2, 4, 6, 15–18 months and once between 4–6 years</p> <hr/> <p><b>IPV (Polio)</b> 2, 4, between 6–18 months and once between 4–6 years</p> <hr/> <p><b>HIB</b> 2, 4, 6, 12–15 months</p> <hr/> <p><b>MMR (Measles, Mumps and Rubella)</b> 12–15 months and 4–6 years</p> <hr/> <p><b>Hepatitis B</b> At birth, 1 month later, 4 months later; if not given before 2 months of age, give at current visit and 1 month later and 4 months later.</p> <hr/> <p><b>Varicella</b> Beginning at 12 months all children who have not been immunized and who have not had chicken pox</p> <hr/> <p><b>Influenza vaccine</b> Annually for healthy children 6–23 months and those 6 months and older with chronic medical conditions or those wishing to obtain immunity</p> <hr/> <p><b>Pneumococcal conjugate vaccine</b></p> <ul style="list-style-type: none"> <li>• Children 2, 4, 6 months and 12–18 months</li> <li>• Children with chronic medical conditions, 24–59 months</li> <li>• Children age 6, one-time catch-up dose</li> </ul> <hr/> <p><b>Hepatitis A</b> Beginning at 24 months, give two doses at least six months apart</p>

The immunization schedule is approved by the *Advisory Committee on Immunization Practices (ACIP)*, the *American Academy of Pediatrics (AAP)* and the *American Academy of Family Physicians (AAFP)*. It is reviewed annually. The immunization schedule coincides with recommended health checkups. For updates on the immunization schedule, check with your doctor or visit [www.bcbsfl.com](http://www.bcbsfl.com).

# Preventive Care Guidelines

## 11–24 years

<b>Screening</b>	<ul style="list-style-type: none"> <li>• Height and weight</li> <li>• Blood pressure</li> <li>• Pap smear (females 18 years and older if sexually active now or in the past)</li> <li>• Chlamydia screen (if sexually active)</li> <li>• Rubella blood test or vaccination history (females over 12 years)</li> </ul>
<b>Health Guidance and Advice</b>	<p><b>Injury Prevention</b> In order to reduce the risk of serious injury, follow these suggestions:</p> <p><b>Diet and Exercise</b> Eating the right foods and regular physical activity will benefit both mind and body.</p> <p><b>Dental Health</b> Maintain good dental health in your family.</p> <p><b>Substance Use</b> Keep your body healthy by following these guidelines:</p> <p><b>Sexual Behavior</b> Be safe from STDs and have a healthy pregnancy by following these suggestions:</p>
	<p>Use seat belts, bicycle helmets and smoke detectors.</p>
	<p>Limit intake of fat and cholesterol; increase consumption of grains, fruits and vegetables; maintain adequate calcium intake (females); exercise regularly.</p>
	<p>Visit your dentist regularly; floss, brush with fluoride toothpaste daily.</p>
	<p>Avoid alcohol, drugs, tobacco and exposure to secondhand smoke.</p>
<b>Immunizations</b>	<p>Practice abstinence or safe sex; take folic acid supplements if considering pregnancy; seek prenatal care within the first three months of your pregnancy. Make sure you and your baby stay healthy by avoiding tobacco, alcohol and secondhand smoke. Before taking any prescription or over-the-counter medications, consult with your doctor. Visit your doctor again within six weeks of delivery or as your doctor recommends.</p> <p><b>MMR (Measles, Mumps and Rubella)</b> 11–18 years (if no previous second dose of MMR)</p> <p><b>Hepatitis B</b> Give at current visit and 1 month later and 4 months later or 2-dose series 6 months apart.</p> <p><b>Varicella</b> 1 dose before age 13 if no history of chicken pox 2 doses after age 13, at least 30 days apart</p> <p><b>Tetanus-diphtheria (Td) booster</b> Every 10 years</p> <p><b>Rubella</b> Females over 12 years and child-bearing age with no documented history of previous immunization against Rubella</p> <p><b>Influenza vaccine</b> Annually for those with chronic medical conditions, pregnancy or those wishing to obtain immunity</p> <p><b>Pneumococcal vaccine</b> Anyone with a chronic medical condition—usually one-time dose</p> <p><b>Hepatitis A</b> Give two doses at least six months apart</p>

The immunization schedule is approved by the *Advisory Committee on Immunization Practices (ACIP)*, the *American Academy of Pediatrics (AAP)* and the *American Academy of Family Physicians (AAFP)*. It is reviewed annually. For updates on the immunization schedule, check with your doctor or visit [www.bcbsfl.com](http://www.bcbsfl.com).

## 25–64 years

### Screening

- Chlamydia screen through age 25 if sexually active
- Height and weight
- Blood pressure
- Pap smear (women every 3 years if still have a cervix or have not had a hysterectomy)
- Mammogram\* and clinical breast exam every 1–2 years (women 50+)
- Stool test or other colon screening beginning at age 50
- Total blood cholesterol and HDL beginning at age 35 for men, 45 for women
- Rubella blood test or vaccination history (women of child-bearing age)

### Health Guidance and Advice

**Injury Prevention** In order to reduce the risk of serious injury, follow these suggestions:

Use seat belts, bicycle helmets and smoke detectors.

**Diet and Exercise** Eating the right foods and regular physical activity will benefit both mind and body.

Limit intake of fat and cholesterol; increase consumption of grains, fruits and vegetables; maintain adequate calcium intake (women); exercise regularly.

**Aspirin Therapy** To lower risk for heart disease.

Men 40 and older, post-menopausal women and younger people with hypertension, diabetes or smokers should take one low-dose aspirin (81–100 mg) unless contraindicated.

**Dental Health** Maintain good dental health in your family.

Visit your dentist regularly; floss, brush with fluoride toothpaste daily.

**Substance Use** Keep your body healthy by following these guidelines:

Avoid alcohol, drugs, tobacco and exposure to secondhand smoke.

**Sexual Behavior** Be safe from STDs and have a healthy pregnancy by following these suggestions:

Practice abstinence or safe sex; take folic acid supplements if considering pregnancy; seek prenatal care within the first three months of your pregnancy. Make sure you and your baby stay healthy by avoiding tobacco, alcohol and secondhand smoke. Before taking any prescription or over-the-counter medications, consult with your doctor. Visit your doctor again within six weeks of delivery or as your doctor recommends.

### Immunizations

#### Hepatitis B

If not fully immunized, give at current visit and 1 month and 4 months later, or give 2-dose series 6 months apart.

#### Varicella

If no history of chicken pox or earlier vaccination, give 1 dose at current visit and next dose at least 30 days later.

#### Tetanus-diphtheria (Td) booster

Every 10 years

#### Rubella

Females over 12 years and child-bearing age with no documented history of previous immunization against Rubella

#### Influenza vaccine

- Annually for anyone with a chronic medical condition or pregnancy
- Annually beginning at age 50 for everyone

#### Pneumococcal vaccine

Anyone with a chronic medical condition—usually one-time dose until age 65

#### Hepatitis A

If not fully immunized, give two-dose series six months apart

\*Your health plan covers a baseline mammogram for women 35–39, a screening mammogram every two years for women 40–49, annually for those 50 and older and for those who are at risk for breast cancer because of personal or family history (based on a physician's recommendation).

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