

BlueCare

For Groups

Understanding Your Health Care Coverage

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

The *Understanding Your Health Care Coverage* 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



You've chosen BlueCare from Health Options[1] 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.

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.

The National Committee for Quality Assurance (NCQA) is an independent, non-profit organization located in Washington, DC 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 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.

[1]Health 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 60 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.

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.

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.

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?"

HMOs have grown increasingly popular because typically 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.

What Does "Managed Care" Mean?

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 (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 (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:

- At enrollment you were required to select a Primary Care Physician (PCP). Seek care from your PCP for your primary health care needs. However, you are not required to obtain a referral from your PCP to visit a participating Health Options Specialist.
- 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.
- 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

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

Please remember these important TIPS:

- Having your PCP coordinate your medical care can save you time and money.
- You are not required to obtain a referral from your Primary Care Physician to seek care from a Health Options participating specialist, or when a specialist refers you to another participating specialist.
- Authorizations are still required for certain medical services including, but not limited to hospitalization, rehabilitation services, home care, select DME, and certain office-based services such as CT scans, MRI/MRAs, cardiac nuclear medicine studies, and select injectables.

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.

Additional information, regarding Behavioral Health Providers, can also be found in your provider directory.

Getting a Second Opinion

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

- 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 for your emergency condition must be coordinated by your PCP or treating participating specialist. If follow-up care is not provided by or coordinated by your PCP or participating treating specialist, 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.

Your Health Care Coverage Goes With You

As a Health Options HMO member, you have access to certain health care services across the country. To meet the different health care needs of members and dependents who are away from home, Health Options offers separate programs for short trips and long-term stays.

For shorter trips, the BlueCard® Program gives you access to doctors and hospitals almost everywhere, giving you the peace of mind that you'll always find the care you need. Non-emergency services rendered outside the Health Options Service Area must be authorized in advance by Health Options in order to be covered services.

For longer trips (90 consecutive days or longer), the Away From Home Care® Guest Membership program may be available for you and your covered dependents in most states and the District of Columbia. For eligibility information and specific locations where the Guest Membership program is available, please contact the customer service number indicated on your Health Options ID card.

This program is designed to bring you peace of mind if you have a dependent attending school out-of-state, have family members living in different service areas, or have a long-term work assignment in another state. Coverage is limited to another Plan's HMO service area.

What to do for Guest Membership

You may call the Customer Service number listed on your HMO 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 have returned the completed enrollment application and 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.

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 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.



How Health Options Makes a Coverage Decision Regarding Medical Necessity



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.

Time-Saving Health Resources

As part of our ongoing commitment to bringing expanded choices and greater value to your health plan, we are pleased to offer a program of discounted products and value-added services called BlueComplements.

BlueComplements is available to you automatically as a plan member at no additional premium cost. And you can access the services throughout Florida and, where available, nationwide. This program includes:

MyBlueService℠* gives you access to online health care information, forms and directories 24 hours a day, seven days a week. To access, go to www.bcbsfl.com and click on MyBlueService to check claims, review benefits, request an ID card, update other insurance, change an address and much more.

BlueComplements℠ provides members with significant discounts* on vision care, hearing exams and hearing aids, contact lenses, bicycle helmets, fitness centers, weight management programs, massage therapy and complementary alternative medicine.

e-Medicine* allows you to communicate with their doctor's office online through a secure and confidential website. Some of the services that may be available include scheduling an appointment, refilling prescriptions and consulting with your physician for non-urgent health care needs. To access e-Medicine, visit www.bcbsfl.com and click on Members and then e-Medicine.

Care Decision Support through Health Dialog®* provides you with health information, health coaching and other health-related programs to help guide treatment choices and decisions about health care. Health Dialog is available to you whenever you need it, 24 hours a day, either by phone or online.

Health Coaches are the most personal aspect of our support programs, providing you with relevant on-the-spot information and health-related videos and written materials if needed. Health Coaches are licensed, experienced health care professionals, including registered nurses, dietitians and respiratory therapists available 24 hours a day, seven days a week.

The Online Provider Directory allows you and your employees to find providers by visiting *www.bcbsfl.com*. Just click on *Provider Directory* to find a provider through Quick Search or by plan, specialty and hospital affiliation through *Assisted Search*. Custom directories can even be printed by plan, region and specialty.

*Blue Cross and Blue Shield of Florida, Inc. (BCBSF) has arrangements with third-party vendors to provide our members with these services. BCBSF does not endorse and is not responsible for the products, services or information provided and cannot guarantee or be held responsible for the quality of services provided by these vendors.

Complaint and Grievance Process

Introduction

Health Options has established a process for reviewing Member Complaints and Grievances. The purpose of this process is to facilitate review of, among other things, the Member's dissatisfaction with Health Options, Health Options' administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care provided by any independent Contracting Provider. The Complaint and Grievance Process also permits the Member, or his or her Physician, to expedite Health Options' review of certain types of Grievances. The process described below must be followed if the Member has a Complaint or Grievance.

Under the Complaint and Grievance Process, a Complaint will be handled informally in accordance with the Informal Review subsection set forth below.

A Grievance will be handled formally in accordance with the Formal Review subsection described below. A request to review an Adverse Benefit Determination of a Pre-Service Claim, Post-Service Claim,







or a Concurrent Care Decision will be handled in accordance with the terms of this section.

Health Options encourages the Member to first attempt informal resolution of any dissatisfaction by calling us. If Health Options is unable to resolve the matter on an informal basis, the Member may submit his or her formal request for review in writing.

Informal Review – Complaints

To advise Health Options of a Complaint, the Member should first contact an Health Options Customer Service Representative at the local Health Options office, either by telephone or in person. The telephone number is listed on the Membership Card, and the address of the local office is listed in the Telephone Numbers and Addresses subsection. The Customer Service Representative, working with appropriate personnel, will review the Complaint within a reasonable time after its submission and attempt to resolve it to the Member's satisfaction. If the Member remains dissatisfied with Health Options' resolution of the Complaint, he or she may submit a Grievance in accordance with the Formal Review subsection below.

Important Note:
The Member must provide to the Customer Service Representative all of the facts relevant to the Complaint. The Member's failure to provide any requested or relevant information may delay Health Options' review of the Complaint. Consequently, the Member is obliged to cooperate with Health Options in our review of the matter.

Formal Review - Grievances

The Member, a provider acting on his or her behalf, a state agency, or another person designated by the Member, may submit a Grievance. To submit or pursue a Grievance on behalf of a Member, a healthcare provider must previously have been directly involved in his or her treatment or diagnosis. The form or letter must be mailed to the address listed in the Telephone Numbers and Addresses subsection.

How To Obtain Forms:
Health Options will provide the Member the form necessary to initiate a Grievance. A form will also be sent with each written decision letter or upon request. The Member may obtain the necessary form by contacting a Customer Service Representative at the local office number listed



on the Membership Card.

While the Member is not required to use Health Options' preprinted form, Health Options strongly urges that the Grievance be submitted on such a form in order to facilitate logging, identification, processing, and tracking of the Grievance through the formal review process.

If the Member needs assistance in preparing the Grievance, he or she may contact Health Options for such assistance. Hearing impaired Members may contact Health Options via TDD.

1. Local Office Review:

a) Standard Grievances

In order to begin the formal review process, the Member must complete a form or write a letter explaining the facts and circumstances relating to the Grievance. The Member should provide as much detail as possible and attach copies of any relevant documentation. The Local Office Grievance Committee will review the Grievance in accordance with the standard Grievance procedure and advise the Member of its decision in writing. If the Grievance involves a Pre-Service Claim, Health Options' decision regarding the Grievance will be made within 15 days of receipt of the Grievance. If the Grievance involves a Post-Service Claim, Health Options' decision regarding the Grievance will be made within 30 days. If the Member remains dissatisfied with the decision of the Local Office, he or she may request a reconsideration of the decision by Health Options' Corporate Office as described in the Corporate Office Review provision.

b) Internal Review Panel Grievance

In the event of a Grievance involving an Adverse Benefit Determination where a coverage determination by Health Options that an admission, availability of care, continued stay, or other Health Care Service has been reviewed and, based upon the information provided, does not meet Health Options' requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested Service is therefore denied, reduced, or terminated, the Member may request that the Grievance be reviewed by an Internal Review Panel. For the Member to have such an Adverse Benefit Determination Grievance reviewed by the Internal Review Panel, Health Options must receive the review request within 30 calendar days from the date that the Member received a denial decision. To request this type of review, send a **written request and supporting documentation** within the 30-day time limit to the address listed in the Telephone Numbers and Addresses subsection.

If Health Options does not receive the request for review by the Internal Review Panel within 30 calendar days, the denial decision will be reviewed by the Local Office Grievance Committee in accordance with the standard Grievance procedure. If the Grievance involves a Pre-Service Claim, Health Options' decision regarding the Grievance will be made within 15 days

of receipt of the Grievance. If the Grievance involves a Post-Service Claim, Health Options' decision regarding the Grievance will be made within 30 days.

The Internal Review Panel will review the Grievance and may make a decision based on medical records, additional information, and input from health care professionals in the same or similar specialty as typically manages the Condition, procedure or treatment under review. The Local Office will advise the Member of its decision in writing.

If the Member remains dissatisfied with the decision of the Local Office, he or she may request a reconsideration of the decision by the Corporate Office as described in the Corporate Office Review provision.

c) Expedited Review of Urgent Grievances

In the event of a Grievance involving an Adverse Benefit Determination, the Member, or a person acting on his or her behalf, may request that the review of the Grievance be expedited. In order for a Grievance to be eligible for expedited review (i.e., a Claim Involving Urgent Care), it must meet the following criteria as determined by Health Options:

1) The Member must be dissatisfied with an Health Options Adverse Benefit Determination;

2) As determined by Health Options, a delay in the provision of Health Care Services for the length of time permitted under the standard Grievance procedure time frames (approximately 30-60 working days) could seriously jeopardize the Member's life or health, or the Member's ability to regain maximum function, or in the opinion of a Physician with knowledge of the Member's Condition, would subject the Member to severe pain that cannot be adequately managed with the care of treatment that is the subject of the claim; and

3) The health care provider involved has refused to or will not provide the needed medical Service without a guarantee of coverage or payment from the Member or Health Options.

The Member, or a provider acting on his or her behalf, must specifically request an expedited review. For example, this request may be made by saying: "I want an expedited review." Only the following Services that have yet to be rendered are subject to this Expedited Review process: (1) Pre-Service Claims; or (2) requests for extension of concurrent care Services made within 24 hours prior to the termination of authorization for such Services.

Information necessary to evaluate a Claim Involving Urgent Care may be transmitted by telephone, facsimile transmission, or such other expeditious method as is appropriate under the circumstances.

A Claim Involving Urgent Care will be evaluated by a health care professional who was not involved in the initial decision and who is in the same or similar specialty, if any, as typically manages the Condition, process, or treatment which you or the provider are requesting be reviewed.

Health Options will make a decision and notify the Member, or the provider acting on his or her behalf, as expeditiously as the Condition requires, but in no event longer than 72 hours after receipt of the request for expedited review. If additional information is necessary, Health Options will notify the provider and the Member within 24 hours of receipt of the Claim Involving Urgent Care and Health Options must receive the requested additional information within 48 hours of request. After receipt, Health Options will make its determination within

an additional 48 hours.

If the Member's request for expedited review arises out of a utilization review determination by Health Options that a continued hospitalization or continuation of a course of treatment is not Medically Necessary, coverage for the hospitalization or course of treatment will continue until the Member has been notified of the determination.

Health Options will provide written confirmation of its decision concerning Claim Involving Urgent Care within two working days after providing notification of that decision. If the Member is not satisfied with the decision, he or she may submit the Grievance to the Statewide Provider and Subscriber Assistance Panel.

2. Corporate Office Review:

In order to appeal the Local Office's decision to Health Options' Corporate Office, Health Options must receive, within 30 days of the Local Office's decision, a form or a letter explaining why the Member feels that the Local Office's decision was wrong or not appropriate and what he or she would like Health Options to do to remedy the matter.

Health Options' Corporate Office will review the Local Office decision as quickly as possible and advise the Member of its decision in writing.

Statewide Provider and Subscriber Assistance Panel

The Member always has the right, at any time, to have a Complaint or a Grievance reviewed by the Florida Department of Insurance or the Agency for Health Care Administration or the Statewide Provider and Subscriber Assistance Panel. The Member may submit the Grievance to the Statewide Provider and Subscriber Assistance Panel within 365 days of the Corporate Office's decision. Telephone numbers and addresses are listed in the Telephone Numbers and Address subsection. The Member must complete the entire Complaint and Grievance Process and receive a final disposition from Health Options before pursuing review by the Statewide Provider and Subscriber Assistance Panel.

Time Frames for Resolution of a Grievance

Health Options will resolve Grievances in a timely manner. In resolving Grievances, time frames may vary depending on the circumstances, between the Local Office and Corporate Office review. Health Options will, however, resolve the Member's Grievance within 30 days after receipt for Pre-Service Claims, or within 60 days for Post-Service Claims.

General Rules

General rules regarding Health Options' Complaint and Grievance Process include the following:

1. The Member must cooperate fully with Health Options in its effort to promptly review and resolve a Complaint or Grievance. In the event the Member does not fully cooperate with Health Options, he or she will be deemed to have waived his or her right to have the Complaint or Grievance processed within the time frames set forth above.

2. Health Options will offer to meet with the Member if he or she believes that such a meeting will help Health Options resolve the Complaint or Grievance to the Member's satisfaction. For the Member's convenience, and at his or her option, he or she may elect to meet with Health Options' representatives in person, by telephone conference call, or by video-conferencing (if facilities are available). Health Options will not reimburse the Member for travel or lodging in connection with any such meeting. Appropriate arrangements will be made to allow telephone conferencing or video conferencing to be held at Health Options' administrative offices within the Service Area. Health Options will make these telephone or video arrangements with no additional charge to you. The Member must notify Health Options that he or

she wishes to meet with Health Options' representatives concerning the Complaint or Grievance.

3. The time frames set forth herein may be modified by the mutual consent of Health Options and the Member, however, any mutually agreed time frame extension does not preclude the Member from having Health Options' decisions reviewed by the Statewide Provider and Subscriber Assistance Panel at any time.

4. Health Options will not honor a request for expedited review that relates to Services that have already been performed, rendered, or provided to you or a request that is not eligible for expedited review in accordance with the criteria set forth in the Expedited Review of a Claim Involving Urgent Care provision. Health Options will process any such Grievance, however, in accordance with the standard Grievance procedure.

5. Health Options must receive all Grievances within one year of the date of the occurrence that initiated the Grievance.

6. If the Grievance involves a determination that the Services did not meet Health Options' Medical Necessity guidelines for coverage of a Service or that the Service is excluded because it meets the definition of an Experimental or Investigational Service or a similar exclusion or limitation, then the Member may request an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of the Member Handbook to the Member's medical circumstances.

7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.

8. The Member may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.

Telephone Numbers and Addresses

The Member may contact an Health Options Grievance Coordinator at the number listed on the Membership Card or the numbers listed below. If a Grievance is unresolved, the Member may, at any time, contact an agency at the telephone numbers and addresses listed below.

Agency for Health Care Administration
Bureau of Managed Care
2727 Mahan Drive
Bldg.1, Room 311
Tallahassee, FL 32308
1-850-487-0640

Department of Financial Services
Office of Insurance Regulation
200 East Gaines Street
Tallahassee, Florida
32399-0322
1-800-342-2762

Statewide Provider and Subscriber Assistance Panel
2727 Mahan Drive,
Building 1, Room 339,
Mail Stop-27A
Tallahassee, Florida 32308
1-850-921-5458
1-888-419-3456

Local Office Locations
Phone: (877) 352-2583
TTY/TDD - Florida Relay 711

Health Options, Inc.
Attention: Grievance Department
4800 Deerwood Campus Parkway DCC4-1
Jacksonville, Florida
32246-8273

Health Options, Inc.
Attention: Grievance Department
4350 West Cypress Street, Suite 400
Tampa, Florida 33607

Health Options, Inc.
Attention: Grievance Department
8400 NW 33rd Street, Suite 100
Miami, Florida 33122-1932

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 have already 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* or call us at the number listed on your HMO Membership ID card.

Coverage for You and Your Family

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.

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 (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 help coordinate 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 can 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.

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 services rendered by a provider who does not participate in the HealthOptions network and that has not been author-

ized 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

As a Member you have the following rights and responsibilities.

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: a) discuss appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage; and b) 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 may also make recommendations regarding Health Options' members' rights and responsibilities policies. Please call the number or write to us at the address on your HMO membership ID 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.

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.

Florida Health Insurance Coverage Continuation Act (FHICCA) Provisions (For employers with one to 19 employees)

Effective January 1, 1997, *Florida Statutes* 627.6692, known as the Florida Health Insurance Coverage Continuation Act, requires that a Small Employer with fewer than 20 employees who does not qualify for the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), offer to Covered Employees and their Covered Dependents the opportunity for a temporary extension of health coverage (called "continuation of coverage") in certain instances where coverage would otherwise end. The Covered Person has certain rights and obligations under the continuation of coverage provision of the law.

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.

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. 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 call the customer service number on your Health Options membership card.

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.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under this Member Handbook with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in this section, shall also constitute an Adverse Benefit Determination.

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

Claim Involving Urgent Care means any request or application for coverage or benefits for medical care or treatment that has not yet been provided to the Member with respect to which the application of time periods for making non-urgent care determinations: (1) could seriously jeopardize the Member's life or health or his or her ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of the Member's Condition, would subject the Member to severe pain that cannot be adequately managed without the proposed Services being rendered.

Coinsurance is the sharing of health care expenses for covered Services between BCBSF and you. This is a percentage of the allowed amount for covered services. Most BlueCare HMO plans have a copayment for covered services, not a coinsurance.

Complaint means an oral (i.e., non-written) expression of dissatisfaction, whether or not such dissatisfaction was made in person, by telephone, or on the Member's behalf.

Concurrent Care Decision means a decision by Health Options to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of



treatment to be provided over a period of time, or a specific number of treatments, if Health Options had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

As defined herein, a Concurrent Care Decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the Case Management subsection as described in the Coverage Access Rules section of this Member Handbook.

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 Coinsurance is the sharing of health care expenses for Covered Services between BCBSF and you. This is a percentage of the allowed amount for covered services. Most BlueCare HMO plans have a copayment for covered services, not a coinsurance.

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

Deductible is the amount you pay before coverage begins for services requiring a deductible. Most BlueCare HMO plans have a copayment structure and do not require a deductible.

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.

Grievance means a written expression of dissatisfaction. The Member, a provider acting on his or her behalf, or a state agency may submit a Grievance.

Health Care Service(s) or Service(s) means evaluations, treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds and other services rendered or supplied, by or at the direction of, providers.

Internal Review Panel means a panel established by Health Options to review Grievances related to Adverse Benefit Determinations made by Health Options that an admission, availability of care, continued stay, or other Health Care Service has been reviewed and, based upon the information provided, does not meet the Health Options' requirements for Medical Necessity, appropriateness, health care setting, level of care, or efficacy. This panel consists of Physicians who have appropriate expertise, and who were not previously involved in the initial Adverse Benefit Determination.

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.

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.

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

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.

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.

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.



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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