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 site 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 has received Commendable accreditation for their Medicare 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.

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: Beginning Jan. 1, 2007, 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 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 (800) 926-6565 for a copy of the provider directory.
If you wish to check a provider’s education, licensing credentials or board certification, call the Department of Health at (850) 488-0595, or link to their website through our online provider directory. For the hearing- and speech-impaired who use a telecommunication device, dial Florida Relay, 711.

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

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

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 MHNet. MHNet 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 MHNet directly at (800) 835-2094, 24 hours a day, seven days a week. For the hearing- and speech-impaired who use a telecommunication device, dial Florida Relay, 711. For copayment and benefit information, please refer to your copayment schedule and Member Handbook.

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.

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 your PCP or a Health Options-contracted specialist does not coordinate follow-up care, coverage for that care may be denied and you may be responsible for the cost associated with that care.

An emergency medical condition is one where failure to obtain immediate medical attention could result in any one of the following:
- Serious jeopardy to the health of a patient, including a pregnant woman or a fetus
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

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

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

Emergencies Out of Your Service Area

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

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

Filing Claims

Always be sure to show your membership card when you receive health care services. When you receive covered medical services and use providers who contract with Health Options, you will not have to file any claim forms. Contracting providers have either already been paid for their services or will file claims for you. If you receive emergency medical services and care from a provider who does not contract with Health Options, you may need to send your bill to Health Options at the address on your ID card. Please call Customer Service first to determine whether or not a claim has been filed.

Customer Service

Call toll free, (800) 926-6565, 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, 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 our customer service representatives toll free at (800) 926-6565, Monday–Thursday, 8 a.m.–9 p.m., and Friday, 9 a.m.–9 p.m., Eastern Time. For the hearing- and speech-impaired who use telecommunication devices, dial 711 for the Florida Relay Service.

Continually Looking at New Technology

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

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

• Approval by an appropriate regulatory agency, such as the U.S. Food and Drug Administration
• Scientific evidence of improved patient outcome when used in the usual medical setting, not just a research setting
• Benefit for patients is equal to established alternatives

To aid in decision-making, expert sources are consulted. These include published clinical studies from respected scientific journals and physicians from various medical specialty organizations.

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

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

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

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

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

**Make Your Wishes Known**

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

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

- A living will
- A health care surrogate designation (a person who has limited decision-making powers)
- A durable power of attorney for health care (a person who becomes an attorney-in-fact and can make all decisions regarding care)
- A do-not-resuscitate order
You may obtain information regarding advance directives from the following sources:
• Your physician or health care provider
• Your local hospital or skilled nursing facility
• The Agency for Health Care Administration (AHCA) website at www.MyFlorida.com (contains downloadable information, forms and a wallet card)

If you have complaints concerning noncompliance with the advance directive requirements, you may contact AHCA at:
Agency for Health Care Administration
Subscriber Assistance Program
2727 Mahan Drive
Bldg.1, Rm. 339
Tallahassee, FL 32308
(888) 419-3456
(TTY users, dial 711)

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

Members’ Rights & Responsibilities

Health Options, Inc., Blue Cross and Blue Shield of Florida’s HMO subsidiary, is committed to offering quality health care coverage, as well as maintaining the dignity and integrity of our members. Recognizing that service providers are independent contractors and not the agents of Health Options, we have adopted member rights and responsibilities as a guideline for our providers. Please refer to your 2007 BlueMedicare HMO Evidence of Coverage for a complete list.

Helping You Make Informed Decisions

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

The AHCA website also provides a link to the Centers for 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.bcbsfl.com, click on Find a Doctor or Hospital, then click on Health Resources under Helpful Links. Look for the link to Florida Health Stat.

Report Card

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

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

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

Member Satisfaction

The Consumer Assessment of Health Plan Survey (CAHPS®) results report member satisfaction with services provided by their doctors and health plans during 2006. 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 compares the responses of Health Options Medicare HMO members with the national average.

We also monitor members’ verbal and written complaints to assess customer needs and expectations. Providing a snapshot of member concerns, this enables Health Options to address member issues one-on-one, as well as develop initiatives to improve service to all members.
### 2006 HEDIS Effectiveness of Care Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Health Options</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>71.33%</td>
<td>NA</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Lipid Profile</td>
<td>90.02%</td>
<td>NA</td>
</tr>
<tr>
<td>- HbA1C Testing</td>
<td>88.32%</td>
<td>NA</td>
</tr>
<tr>
<td>- Dilated Retinal Exam</td>
<td>15.09%</td>
<td>NA</td>
</tr>
<tr>
<td>Beta Blocker Treatment After Heart Attack</td>
<td>94.44%</td>
<td>NA</td>
</tr>
<tr>
<td>Cholesterol Screening After Acute Cardiovascular Event</td>
<td>92.46%</td>
<td>NA</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>64.23%</td>
<td>NA</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>54.07%</td>
<td>NA</td>
</tr>
</tbody>
</table>

HEDIS® is a registered trademark of NCQA. Source: NCQA’s 2007 State of Health Care Quality *Does not include Commercial HMO members

### 2005 Member Satisfaction Measures***

<table>
<thead>
<tr>
<th>Measure</th>
<th>Health Options</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Courteous and Helpful Office Staff</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Health Plan Customer Service</td>
<td>67%</td>
<td>73%</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td>75%</td>
<td>84%</td>
</tr>
<tr>
<td>Getting Needed Care</td>
<td>84%</td>
<td>86%</td>
</tr>
<tr>
<td>How Well Doctors Communicate</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>Overall Rating of Health Care Received</td>
<td>84%</td>
<td>86%</td>
</tr>
<tr>
<td>Overall Rating of Health Plan</td>
<td>64%</td>
<td>79%</td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>Rating of Specialist</td>
<td>83%</td>
<td>84%</td>
</tr>
</tbody>
</table>

*Does not include Commercial HMO members

**Source: 2006 Medicare CAHPS®. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

***The 2007 Medicare CAHPS® information will not be available until November 2007. This information will be updated at that time.
Improvement Initiatives

Health Options continuously tries to improve the quality of care and services for our members. Many of our improvement initiatives this past year were focused directly on helping you improve your health. Other initiatives were focused on improving our service to members.

**Member and Provider Education:**
- Education targeting preventive care, including immunizations, was mailed to members and placed on the BCBSF web site.
- Follow up letters were sent to members who had not received breast cancer screening, colorectal screenings or diabetic who had not received a dilated retinal exam (DRE) according to the latest guidelines.
- Primary Care Physicians (PCP) who prescribe anti-depressants were identified and provided information regarding the latest practice guidelines for patients with depression.
- Informed providers & staff at the BlueNews Seminars on documentation of care guidelines, prevention screening criteria, advance directives, problem lists, practice guidelines for depression, controlling high blood pressure guidelines, patient safety tips & patient communication tips.
- Educate providers on doc guidelines, Florida Shots Program, Florida Healthy Kids Program and advance directives in provider on-line newsletter.

**Member Satisfaction**
- Removed the requirement for a referral from the PCP when seeking care from a specialist participating in the network.
- Satisfaction surveys were translated into Spanish to give more of our members a chance to be heard.
- Improved data collection and reporting techniques were developed to better identify member needs.

**Care Coordination**
- Internal systems were updated to improve our Case Managers’ ability to help you when you have a catastrophic event or chronic illness.
- A Care Advocate program was implement to assist you in using the decision support tools available to members, understand your benefits, locate preferred providers in your area and explore community resources.

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

Health Options’ mental health service network is administered by Mental Health Network (MHNet). MHNet follows NCQA standards regarding your ability to reach a provider easily and to get an appointment in a timely manner. They also evaluate quality improvement and utilization management activities and conduct member satisfaction surveys. MHNet’s Quality Improvement Committee continues to address areas related to overall member satisfaction. Upon request, MHNet will make available to its enrollees information about its Quality Improvement Program, including a description of the program and a progress report on meeting their goals. To request a copy from MHNet, call (800) 835-2094. For TTY, call the Florida Relay Service at 711.

**Preventive Care Guidelines**

Working with your primary care physician to stay well is as important as receiving treatment when you are sick. The latest United States Preventive Health Task Force guidelines are available at web address below. This information will help you and your doctor make sure you get the tests, immunizations (shots) and guidance you need to stay healthy at the different stages of your life.

We encourage you to talk with your doctor about these recommendations and ask questions if you don’t understand something. Bring this information to your doctor when you have an appointment. It is best to make appointments for preventive care check-ups at least six weeks in advance.