For Members of Individual HMO POS QHP Plans

Health First Health Plans

Member Guidebook

6450 US Highway 1, Rockledge, FL 32955

Toll-free 1.855.443.4735
TDD/TTY relay 1.800.955.8771
Monday through Friday 8 am to 6 pm

myHFHP.org

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Table of contents

About this guidebook

This Member Guidebook contains important information about your health benefits. It provides general information about how your Health Plan works so that you can make educated decisions for you and your family.

This guidebook is designed to help you get the most out of using your plan. Refer to your specific Schedule of Benefits for information on your coverage, as benefits can vary widely by plan. For comprehensive information on your plan's provisions, your *Certificate of Coverage* is considered your most important Plan Document and will be your best resource for benefit information. You can view and print most Plan Documents online. Log in to our member portal at myHFHP.org/login. Or, contact Customer Service if you need a copy.

This Member Guidebook is not intended to create, and shall not create, any rights or obligations that differ from, or are inconsistent with those set forth in your Plan Documents. In the event of an inconsistency, the Plan Documents will prevail.

At your service

If you have a question about your health benefits plan, need information or materials, or have a problem, there are several ways to contact us to obtain the assistance you need. We also welcome any suggestions you may have on how we may better serve you. Contact us any way you choose.

On the Internet

When you log in to our member portal at myHFHP.org/login, you will be able to:

- Review and print your Plan Documents, including your Schedule of Benefits, Certificate of Coverage, and any applicable riders and amendments, which explain your benefits and payment responsibilities.
- Print or request a new member identification (ID) card.
- Find a participating physician, specialist, hospital, pharmacy or urgent care center.
- Check member eligibility.
- Get details on claim payments, deductibles, and Explanation of Benefits (EOB).
- Contact us with a question, suggestion, or to report a problem.

By telephone

If you have questions about your plan or need assistance in a language other than English, please contact Customer Service toll-free at 1.855.443.4735 (TDD/TTY:1.800.955.8771).
Our Customer Service hours are:
Monday through Friday from 8 am to 6 pm.

Automated services are available around the clock.

A helpful hint:
Phone volume is heaviest on Mondays and from 11 am to 3 pm on other days. If you need to speak with a representative, you may minimize delay by calling at other times.

By email

Please send your question or comments to: hfhpinfo@health-first.org.

By fax

Please send your fax to: 1.855.328.0062

By mail

Please mail correspondence to:
Customer Service
Health First Health Plans
6450 US Highway 1
Rockledge, FL 32955

In person

We offer walk-in service Monday through Friday. You do not need to schedule an appointment to visit us in person. Our walk-in service is located at:

Health First Health Plans
6450 US Highway 1
Rockledge, FL 32955
Monday through Friday
8 am to 5 pm

2040 Treasure Coast Plaza
Vero Beach, FL 32960
Monday through Friday
8:30 am to 5 pm

Language access

The plan has a long-standing commitment to providing full services for our ethnically diverse membership:

- **Language services available through Customer Service.** This service provides over-the-telephone interpretation services in more than 100 languages, including Spanish, French, Portuguese, Russian, Chinese, Japanese and Korean.
- **Bilingual and multi-lingual physicians and staff.** Many of our participating providers working in private offices speak more than one language. Please refer to the Provider Directory for providers that speak other languages.
- **TDD/TTY access.** If you are hearing- or speech-impaired, we have TDD/TTY relay access numbers that you can use to make an appointment or to speak with a customer care representative.

Collection of race, ethnicity, and language information

- To meet our members' linguistic needs and provide culturally appropriate services, we need information to help us create additional programs and resources. When calling Customer Service, speaking with your case manager, or any of the Health Plan staff, you may be asked for your demographic information.
- We are committed to providing health care to all our members regardless of race, ethnic background, or language preference. It will be entirely your choice whether to provide us with your demographic information. The information is confidential and will be used only to improve the quality of care for you and our other Health Plan members.

What if I move?

We want to make sure you receive your health benefit information. Please let us know when you change your name, address or phone number. Also, be sure to report any change that has occurred in your family status since your initial enrollment, such as adding a dependent or newborn.

Other contact numbers

For mental health/substance abuse treatment, call Magellan toll-free at 1.800.424.4347 (TDD/TTY access 1.800.424.1694).
For Pediatric Dental, call Delta Dental at the following toll-free numbers:
HMO Members 1.800.471.9925
24 Hour Nurse Line toll-free: 1.800.308.5848
Health First Family Pharmacy toll-free: 1.866.469.1506

How your benefit plan works

Your member identification card

You will receive member identification (ID) cards listing your enrolled dependents. Keep your ID card with you in a safe, easy-to-reach place, and take it with you when you travel in case of an emergency. Present this card to the health care provider whenever you seek medical services or to the pharmacy when filling a prescription. The card has the information the provider and/or pharmacy needs to verify your benefits and bill us for the services you receive.

If you did not receive an ID card, or if a card has been lost, you can request a new one online in our member portal at myHFHP.org/login.

Eligibility & enrollment

Who is eligible to enroll?

We offer several types of plans, including options for individuals and families. If you live in our service area and qualify for one of these options, we welcome you to explore the advantages of Health First Health Plans and Insurance. Our service area includes all of Brevard and Indian River Counties.

Eligible dependents

An eligible dependent is defined as one of the following:
a) The subscriber's lawful spouse.

b) The subscriber's domestic partner (as defined in the Glossary of terms section of this Guidebook).
c) The subscriber's, covered spouse's, or covered domestic partner's child who has not reached the end of the calendar year in which he or she reaches age 26.
d) The newborn child of a covered dependent child up to 18 months after birth of such newborn.

The Affordable Care Act requires Health Plans to offer dependent children continuity of coverage until the child reaches the age of 26. In addition, Florida law requires fully-insured plans to offer continuity of coverage for dependent children after the child turns 26 until the end of the calendar year in which he or she turns 30 if the child:

a) is unmarried without dependents of their own;

b) is a state resident or a full or part-time student; and

c) is not provided coverage under any other group or individual insurance policy or entitled to Federal or State benefits.

The term "child" includes the subscriber's or covered spouse's natural born child, stepchild, foster child or legally adopted child of the subscriber upon placement in the subscriber's residence, provided proof of such guardianship is presented. In the case of the birth of a newborn adopted child, a written agreement to adopt such child has been entered into prior to the birth of the child.

How do I enroll?

You can enroll in Individual coverage during the Open Enrollment Period. Outside of the annual Open Enrollment Period, you can enroll only if you have a qualifying life event. Examples of qualifying events include loss of health care coverage, moving outside of your insurer's coverage area, or marriage. For more information, visit healthcare.gov.

You can find an application on our web site at myhfhp.org or ask your insurance agent or contact us directly at 1.877.904.4914 for a copy.

You may also enroll through the Federally Facilitated Marketplace (FFM) at healthcare.gov. The FFM follows enrollment rules specified by the Federal Government and the State of Florida. These enrollment rules may or may not apply if you enroll in this plan directly with us. If you enroll in this plan through the FFM, you may be eligible for tax credits to help pay for your cost of coverage.

How do I enroll my newborn child?

If you are expecting a child, we encourage you to find out how to add your newborn child to your Health Plan. If this is your first child, you will also want to select a participating pediatrician, review your plan's pediatric benefits and familiarize yourself with the recommended childhood immunization schedule.

A newborn child will be covered from the date of birth as long as you notify the plan within 60 days of birth. If you notify the plan within the first 31 days, premium is not charged for the first 31 days of coverage. If you enrolled through the FFM, you must enroll your newborn child by accessing your Marketplace account at healthcare.gov.

If you do not enroll your newborn within 60 days of birth, you will not be able to add your child to your policy until the next Open Enrollment Period.

How do I enroll other dependents?

Eligible dependents can be included when you initially enroll, during the Open Enrollment Period, or within 60 days after a qualifying event. An example of a qualifying event is the loss of other health care coverage. There are other special circumstances that qualify for special enrollment periods. For more information, you may contact us or visit healthcare.gov.

If you enrolled through the FFM, you must enroll your eligible dependent by accessing your Marketplace account at healthcare.gov.

When does my coverage end?

If you have to cancel your membership, you may do so at any time by notifying us in writing. If you enrolled through the FFM, you must request

disenrollment by accessing your Marketplace account at healthcare.gov. Please be aware that once you dis-enroll, you will not be able to enroll in another Individual policy until the next Open Enrollment Period, unless you qualify for a Special Enrollment Period.

You may rest assured that the plan cannot cancel your membership for health reasons. Only the following situations can cancel your or your dependent's membership:

- You or your dependent no longer meets eligibility requirements.
- You relocate outside our service area.

Coverage may also be terminated for the following reasons:

- If you provide false or incomplete information affecting eligibility or plan administration. In this event, coverage will be canceled and you will be responsible for all expenses related to the material misrepresentation.
- If you use or permit another person to use a membership ID card not belonging to them for purposes of obtaining health care. In this event, coverage will be canceled and you will be responsible for all expenses resulting from the misuse.
- If your behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that continuing membership seriously impairs our ability to furnish service to you or other members.
- If you do not pay your premium as described in your Evidence of Coverage.

My financial obligations

What will my expenses be?

Every plan is different, and your financial obligations will vary based on your specific plan. You are responsible for your premium and any cost sharing your plan requires. Additionally, some medical services may not be covered by your plan.

If you obtain services that are not covered by your plan, you will be financially responsible. Make sure to familiarize yourself with the benefits provisions, exclusions, and limitations of your plan *before* you seek services so you do not incur unnecessary or unexpected expenses.

Using participating providers and preferred drugs will help reduce your expenses significantly.

To verify the cost sharing you will have for specific services, refer to your Schedule of Benefits, or you may contact us for assistance.

Preventive benefits

We believe in preventive care and comply with federal laws that require coverage of certain preventive services without member cost-sharing. By law, the following services are covered in full under your plan when obtained in-network:

- Services recommended by the U.S. Preventive Services Task Force (USPSTF) with a current rating of A or B.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) for routine use in children, adolescents, and adults.
- Preventive care and screenings for women, infants, children, and adolescents that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Preventive benefits are available for annual physicals, certain vaccines, and screening tests, including, but not limited to, those for diabetes, certain types of cancer, and other medical conditions. Preventive benefits also include counseling for a variety of behavioral issues. For a complete list of preventive benefits, visit www.healthcare.gov.

Important Note: Preventive coverage is subject to change based on current official recommendations, which can be found at healthcare.gov. Some preventive services may require prior authorization or have special provisions. Please visit our website, myHFHP.org, or contact us for more information.

What is a deductible?

A deductible is a set dollar amount that you must pay for covered medical services each year before your Health Plan starts paying for certain benefits. Once you satisfy your individual or

family deductible requirements, your medical care will be covered according to the terms of your plan. Some plans include a separate deductible for prescription drugs. For most plans, a new deductible must be met every calendar year. Refer to your plan documents to see when the deductible starts over for your plan.

What does "out-of-pocket maximum" mean?

The out-of-pocket maximum protects you from catastrophic medical expenses by limiting how much you have to pay during the benefit year.

Here's how it works: As you receive covered services during the year, usually you pay part of the cost (your cost share) and we pay part. When the total amount **you have paid** reaches the amount of your out-of-pocket maximum, we start paying the full cost of your covered care. Depending on your plan, there may be services that do not count toward the maximum and a few may not be covered at 100% after you reach the out-of-pocket maximum. With some plans, prescription drug costs count towards the maximum. See your plan documents on the member portal at myHFHP.org/login for details.

What is the difference between a copayment and coinsurance?

"Copayments" and "coinsurance" are types of member cost sharing, and they represent the portion of medical expenses members must pay.

A copayment is a *flat dollar amount* that a member pays for a covered service, while a coinsurance is a *percentage* of the medical expenses that a member pays, stated as a percentage of allowable charges.

Are there any lifetime limits or annual maximums?

The Affordable Care Act (ACA) prohibits any Health Plans to apply lifetime limits or annual dollar maximums to "essential" benefits. However, the law does not prohibit annual maximums on non-essential benefits. The most current information on essential benefits can be found at www.healthcare.gov. Read your Schedule of Benefits in your policy to make sure you are aware of any limits on the number of visits or services or frequency limits on some benefits.

Are there limits for pre-existing conditions?

There are no limits or exclusions for pre-existing conditions for policy years beginning on or after January 1, 2014. If your current policy was purchased prior to January 1, 2014, your coverage may include a pre-existing clause.

With a POS plan, how much do I pay for services outside of the network?

Point of Service (POS) members can see any provider they choose for covered services, regardless of whether or not the provider is a participating provider. Since your cost depends on whether the provider participates with us, you can save money by using Health First providers whenever possible. Actual costs will depend on the benefit plan you have, the providers you see, and the services you receive. Your plan documents show your share of the cost for receiving services both in and out of our network.

Whether you use participating or non-participating providers, some services require prior authorization. Your participating physician will have this information, but non-participating physicians probably will not. You can find the list of services requiring prior authorization on the member portal at myHFHP.org/login. or you may contact Customer Service.

IMPORTANT NOTE: If a non-participating provider charges more than your plan's fee schedule allows, you will be responsible for paying that extra amount, in addition to the applicable coinsurance. The additional cost to you for out-of-network care can be substantial. Please contact us if you need assistance accessing a participating provider so you can receive the best coverage under your plan.

If you are seeing a participating provider, you are responsible for paying only you're your "in-network" cost share. If you see a provider who is *not* part of our network, you are responsible for paying the higher "out-of-network" cost share. We do not have contracts with these providers limiting the amount they can charge for services, so if they charge more than our allowable amount, you may be responsible for the additional cost (also called "balance billing"). Out-of-network providers are not required to see you and may require you to pay up front for services and submit your own claim.

When seeking out-of-network services, we encourage you to talk with your provider in advance. Ask what the charges for the service will be and if they will accept our fee schedule. Some providers will agree, which could reduce your total cost.

There are some providers outside of our network and service area who are part of a national network we have contracted with, who have already agreed to accept a reduced rate. If this rate is higher than our allowable fee schedule, you'll still be responsible for the difference, but seeing these providers is another way to help limit your out-of-pocket expenses. For more information on these providers, visit Multiplan.com.

Financial Responsibility Examples:

In-Network	
Allowed Amount	$500
Coinsurance	20%
You Pay (20% x $500)	$100
Plan Pays (80% x $500	$400
Provider Charges	$500
Balance Bill	$0
Your Total Cost	**$100**

Out-of-Network	
Allowed Amount	$500
Coinsurance	40%
You Pay (40% x $500)	$200
Plan Pays (60% x $500	$300
Provider Charges	$750
Balance Bill	$250
Your Total Cost	**$450**

Doctors and other providers

Can I choose my own doctor?

You can choose to see any doctor in our network without a referral, including specialists. POS plans provide more options because you may seek covered care from non-participating providers as well as participating providers.

Regardless of which type of plan you have, we do not require you to select a primary care physician (PCP). However, it is important to establish a relationship with a doctor for your preventive and primary care. Your PCP is also a good way to coordinate any specialty care you may need.

Physician assistants, nurse practitioners, and others who are not licensed as physicians offer many medical services. These services are rendered in accordance with Florida regulations and require the same cost share as you would pay for seeing a physician.

How do I find a participating doctor or provider?

The Provider Directory will list participating doctors, along with information on their credentials, languages spoken, age limitations, if any, and whether they are accepting new patients. It also lists other participating providers like hospitals, outpatient surgery centers, pharmacies, labs, etc.

If you need to find a provider visit myhfhp.org for an online provider search or request a complete Provider Directory. You can also contact Customer Service for additional information on doctors' professional qualifications.

If you are not sure which physician to choose, friends and family are good sources for candid reviews of providers. Once you select a primary care physician (PCP), he or she will be another good resource for selecting any required specialists.

All members have access to our participating providers. There are some providers outside of our network and service area who are part of a national network we have contracted with who have already agreed to accept a reduced rate. For more information on these providers visit Multiplan.com.

Obtaining covered medical and behavioral health care

How do I get medical and behavioral health care?

The way you obtain routine medical and behavioral health care will depend on the type of plan you have. Benefits and cost-sharing requirements will also vary from plan to plan. Be sure to check your plan documents on the member portal at myHFHP.org/login.

General provisions: Generally speaking, HMO plans require you to see participating providers for covered services, except for urgent care outside the service area or emergency care. All other out-of-network services must be authorized in advance by the plan or they will not be covered. It's important to remember this provision, especially when you're outside our service area for any reason. If you're enrolled in an HMO plan, it is very important that you know whether or not your provider participates with us so you don't incur charges for services that may not be covered.

If you have a POS you may see non-participating providers but your costs may be higher than if you receive the services in-network from participating providers. These types of plans offer more choices in the delivery of health care, but typically include higher premiums and out-of-pocket costs. If at all possible, try to locate a provider that is part of our contracted national provider network, as we have negotiated preferred pricing through this network for out-of-area care. You can locate one of these providers at Multiplan.com.

Primary care: To access primary care, simply contact your primary care physician (PCP) to make an appointment. For after-hours care, you can call your doctor's answering service 24 hours a day for instructions.

Emergency care: If you are experiencing a medical emergency, have someone take you to the nearest emergency room. If you cannot get to the emergency room safely and quickly, call 911. When you are able, be sure to show your member ID card. If you are admitted to the hospital or need help coordinating your care after you are stabilized, have someone contact us and your PCP for assistance. We cover emergency medical care anywhere in the world and will help arrange for your transfer home if necessary.

Urgently-needed care: If you need care after hours or urgently, but it is not an emergency, participating urgent care centers are open evenings and weekends. For your convenience, we now have an online waiting service at HFNow.org. The website and mobile application allow you to check in and wait at home. Avoiding unnecessary trips to a hospital emergency room can save you time and money.

HMO members who access urgent care in the service area **must** use a participating urgent care center. You may find a list of participating urgent care centers in your Provider Directory and on our website at myhfhp.org.
If you are outside the service area, you are covered for unforeseen illnesses or injuries that need to be treated immediately. Simply locate an urgent care clinic or other physician for the initial treatment. Then, contact your local doctor to obtain any necessary follow-up services.

24 Hour Nurse Line: You may also contact Nurse24 at 1.800.308.5848 if you have a question that you would like answered by a health care professional. This toll-free line is available 24 hours per day, 7 days per week.

Hospital care: If you need to be hospitalized and it is not an emergency, your doctor must get authorization from us first and coordinate your admission. Authorizations may be required for some outpatient services performed at a hospital, but if you see a participating doctor, he

or she will know if that's necessary and can take care of it for you.

You *never* need authorization for emergency care at *any* hospital. If you are admitted to a non-participating hospital as part of your emergency care, please have someone contact us toll-free at 1.855.443.4735. We can help coordinate your care after you are stable.

Behavioral health care: These services, also known as "mental health care," can be accessed directly without a physician referral as with other specialty care. You may call Magellan toll-free at 1.800.424.4347 (TDD/TTY access: 1.800.424.1694) to arrange the appropriate services. A behavioral health professional will assist you with obtaining the help you need. POS members can access the provider of their choice with applicable cost-sharing amounts.

When do I need a referral or authorization?

To make it easy for you to obtain medical care, we do not require members to get a referral to see participating specialists for covered services. However, some specialists may require a referral from your primary doctor to ensure your care is coordinated properly. To locate a participating provider for specialty care, please see your Provider Directory or contact us for assistance.

While most covered medical care can be obtained without our involvement, some services require prior authorization by our Medical Management staff to ensure the right care is provided in the right setting. Your participating physician will assist you by contacting us for services that require prior authorization. Please note that referrals and prior-authorized services are still subject to any exclusions or limitations of your plan.

Certain services require prior authorization to be covered, and POS members receiving care from non-participating providers are responsible for ensuring that authorization is obtained. A few examples of services that require prior authorization include MRI, PET, CT scans and nuclear cardiology studies. However, other services require authorization, and the Authorization List is subject to change.

If you are using a provider who does not participate in our network (including our contracted national provider network), please be sure you discuss the authorization process with your provider, notify the plan, and ensure the service is approved in advance of receiving it. You have the ultimate responsibility to notify your non-participating physician that authorization is required for these procedures. If your physician has any questions or needs instructions on how to obtain prior authorization, he or she may visit myHFHP.org.

Please check the current Authorization List to see if approval is required in advance. This will ensure you do not incur any unexpected expenses for services that may not be covered. You can get the Authorization List from myHFHP.org.

What if I need a second opinion?

You are entitled to a second opinion. If you are an HMO member, second opinions by non-participating doctors must be authorized by the plan in advance. Cost share for a second opinion by a non-participating doctor is 40% of the allowed amount. There is a maximum of three second opinions allowed for any one calendar year. If we require you to get a second opinion, all charges related to that second opinion will be covered in full.

Decision making

We are committed to providing you access to quality care. All decisions involving coverage are based on appropriateness of care and service. We do not compensate practitioners or any other individuals for making decisions that could result in denials of care. Denials are based on medical necessity or contract provisions. The plan works to prevent inappropriate decision making by regularly monitoring all medical claims and requests for care.

Prescription drugs

How do I know what drugs are covered by my plan?

We maintain a drug list, also called a formulary, which is an extensive list of safe and effective, FDA-approved, brand name and generic prescription drugs used to treat the most common medical conditions. The Health First Pharmacy and Therapeutics Committee (P&T), a panel of physicians and pharmacists, develops our drug list and updates it regularly. The list includes quality drugs available to you at reasonable cost. Only those medications that have successfully passed federally required clinical testing and evaluation and have been proven effective are included. The P&T Committee reviews and evaluates all available literature about a drug when updating the list.

How much will I pay for a covered drug?

Every plan is different, and your financial obligation will vary based on your specific plan. You are responsible for any cost sharing your plan requires. Most covered prescription drugs will be categorized into one of five tiers. The cost of drugs varies widely, even though several different medications may be used to treat the same condition. What you pay for the prescription depends upon what tier the drug is listed in. We offer many benefit plans that can vary in coverage for each tier. Details about your specific benefit for each tier are included in your Schedule of Benefits. Prescriptions that exceed a 30 day supply will default to a 90 day supply copay (this does not apply to coinsurances). For coinsurances, you will always pay a percentage of the total cost after the applicable deductible is met.

To verify the cost sharing you will have for specific tiers, refer to your Schedule of Benefits. To get updated information about covered drugs, please visit our Web site at myHFHP.org or call Customer Service toll-free at 1.855.443.4735 (TTY/TDD relay: 1.800.955.8771) Monday through Friday from 8 a.m. to 6 p.m.

How often is the formulary updated?

In order to continue to offer a safe and cost effective selection of prescription drugs, Health First periodically makes changes to the Drug List. These changes may include removing medications, adding restrictions, and/or covering a drug at a higher tier. Updated formularies are posted to the website as changes are made. The following list represents some of the most common scenarios in which changes to drug coverage will occur:

- Throughout the year, new medications are approved by the FDA. It is the policy of Health First that new drugs will be excluded for 6 months from the date of FDA approval, during which time the Health First Pharmacy and Therapeutics Committee can review the drug for safety and efficacy.
- The Drug List may change when a medication is withdrawn from the market due to safety reasons or if it becomes available over-the-counter (OTC). At the time that a medication on the Health First Drug List becomes available OTC, it may be excluded from coverage from that point forward.

When a brand-name prescription drug loses its patent and the equivalent generic form is added to the Drug List, the brand-name drug may be moved to the highest non-specialty drug tier, which is generally Tier 4, or removed from the formulary.

For a current copy of your formulary or to get updated information about covered drugs, please visit our Web site at myHFHP.org or call Customer Service toll-free at 1.855.443.4735 (TTY/TDD relay: 1.800.955.8771) Monday through Friday from 8 a.m. to 6 p.m.

What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Customer Service and confirm that your drug is not covered. If you learn that Health First does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by Health First. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Health First.

- You can ask your physician to send Health First information requesting we make an exception and cover your drug.

If Health First approves you or your physician's request for an exception to the Health First formulary the approved drug will be covered at the Tier 4 cost share. If the cost of the medication is greater than $500 per month it will be covered at the Tier 5 or Specialty Tier. For additional information on the obtaining a formulary exception, please visit our web site at myHFHP.org or call Customer Service toll-free at 1.855.443.4735 (TTY/TDD relay: 1.800.955.8771) Monday through Friday from 8 a.m. to 6 p.m.

How can I make the most of my prescription drug benefit?

The costs of prescription drugs continue to rise every year and can represent a significant part of your healthcare expenses. Your Health Plan can help you pay for your medications by sharing the cost with you and providing substantial discounts for medications you purchase. To help you manage your prescription drug costs, here are some money-saving tips to consider:

- **Use Tier 1 generic medications whenever possible.** Generic drugs are the chemical equivalent of brand-name drugs, and are just as effective in most cases. If you take generic drugs you will generally pay less, so talk to your doctor about switching to a generic equivalent of any brand-name you are taking if it is appropriate. In addition, many of our prescription drug riders include a $2 copayment for Tier 1 generic drugs ensuring affordable access to many commonly prescribed medications. Please see the list of drugs below to determine which drugs are included in Tier 1.
- **Consider using the mail order program through Health First Family Pharmacy for maintenance drugs.** When you purchase your regular medications through the mail, you may save money by ordering a 90-day supply. If you want to take advantage of this option, let your doctor know so you can have a prescription written for a 90-day period if appropriate and available. For additional information on the Mail Order Program, please visit our web site at myHFHP.org or call Customer Service toll-free at 1.855.443.4735 (TTY/TDD relay: 1.800.955.8771) Monday through Friday from 8 a.m. to 6 p.m.
- **See if your prescription pills can be split in half.** For some medications, pills may be available in different strengths but still have the same price. If you need one of these select medications, your doctor may be able to write your prescription so that you can get your pills at double strength, but half of the number of pills you'd normally need, and you'd only pay half of the regular price. Then you'd split them in half, so you'd get the proper dose—saving up to 50 percent of the cost! The drugs that may be eligible for the Pill-Splitting program are marked with the symbol **(1/2)** on the drug list, so review this information with your doctor if your drug qualifies.
- **Shop around for the best price.** For prescription drugs with a fixed copayment, your share of the cost would be the same at any of our participating pharmacies, however, if your plan includes prescriptions with a deductible or coinsurance (a percentage of the cost), you can often save money by comparing prices at different pharmacies. Although we have negotiated competitive rates with all of our participating pharmacies, the price may be different from store to store, and can change from day to day. Please do not hesitate to contact the Customer Service Department to ask how much your medication will cost.

How do I get reimbursed for prescription drugs?

If you have to pay for prescription drugs yourself for any reason, you can be reimbursed according to the provisions of your plan. Please send your detailed pharmacy receipt to us along with a written reimbursement request. You should include your name and member number for reference. Although it is not necessary, you can obtain a Prescription Drug Reimbursement Form by visiting our website at myHFHP.org. Your reimbursement request can be faxed to 1.855.328.0061 or mailed to:

Health First Health Plans and Insurance
Attn: Pharmacy Department
6450 US Highway 1
Rockledge, FL 32955

Please do not send original documents.

Claims

How do I get reimbursed for medical expenses?

You should rarely need to file a claim since participating providers will submit claims for you. However, if you receive medical care from non-participating providers, you may be required to pay for the services yourself and request reimbursement later. While it is preferable to have your provider submit a valid claim form to us, you can also request reimbursement by sending us an itemized bill within six months that includes the provider's name, address, phone number, and tax ID number, along with a detailed list of the services you received and the amount you were charged and paid. It's important for your receipt to include procedure and diagnosis codes so we can process your payment promptly and accurately. Be sure to send a note that explains your request and we will reimburse you according to your benefit plan within the allowed time frame. If reimbursement is denied for any reason, you will receive an Explanation of Benefits (EOB) that explains why.

Please send original documents, but keep copies for your own records. Your reimbursement request should be mailed to:

Health First Health Plans Attn: Claims Department
6450 US Highway 1
Rockledge, FL 32955

For information on reimbursement for prescription drugs, see the section on Prescription Drugs.

Coordination of benefits (COB)

Some Health Plan members are also covered under another Health Plan. Examples include a spouse's plan, Workers' Compensation, No-Fault, or Personal Injury Protection. If you are covered under another Health Plan, please be sure that you file your claims with your primary insurer. This is the insurer with whom you have a contract or certificate of coverage.

If the reimbursement you receive is less than the full charge for the service, you can submit a claim to a secondary insurer. This is the insurer that covers you as a dependent or spouse of the person who has the contract or certificate of coverage with that plan. For more information on how COB works, please see your plan documents.

What if I do not agree with the decision on my claim?

If you do not agree with a coverage decision, either before or after a service or procedure is obtained, you have the right to appeal. Simply send a signed and dated written appeal within the time frame stated on your denial notice to:

Health First Health Plans and Insurance
Attn: Appeals
6450 US Highway 1
Rockledge, FL 32955

You can also fax to 1.855.328.0053. For more information, refer to the section *Concerns, grievances, & appeals* below.

Concerns, grievances, & appeals

We understand that there may be a time when you are not satisfied with our services or providers, or when you disagree with a decision that is made. Rest assured, we are committed to working with you to find a resolution if this happens, as well as providing you with timely, fair processes to have your concern addressed. We offer an informal concern process, a formal grievance procedure, and also a formal appeal procedure. If your appeal relates to medical care you need, we will expedite the review of your appeal as urgently as the situation requires to ensure your health is not jeopardized while you wait for a decision.

Concerns

If you have a concern about our services or providers, or you disagree with a decision that is made about your coverage, many of these problems can be resolved by talking with a Customer Service Representative. Simply contact us with any concern. You can do this by

phone, in person, or in writing, and we will provide you with immediate and active assistance. We will make every attempt to resolve the problem within three (3) working days and will always document your concern for quality improvement purposes.

Grievances

A grievance is a formal complaint regarding service issues or the quality of care.
If you do not like the result of the concern process and you would like us to reconsider, or if you would rather not discuss your problem with a Customer Service Representative, you may file a formal grievance in writing. Just give us a description of the issue and how you would like it resolved. Be sure to sign and date your written request. We can help you if you need assistance. Grievances must be submitted within one (1) year of the event causing the Grievance.

You can mail, deliver, e-mail, or fax your grievance to:

Health First Health Plans and Insurance
Attn.: Grievances
6450 US Highway 1
Rockledge, FL 32955
Fax: 1.855.328.0053
E-mail: hfhpinfo@health-first.org
8 am to 5 pm, Monday through Friday

Appeals

An appeal is a formal dispute regarding an adverse coverage determination (denial of coverage or application of cost-share. If you have a problem regarding your coverage, you can file an appeal.

First level of review

Standard appeals must be submitted in writing by you or your authorized representative within one (1) year of being notified of an adverse coverage determination. Your appeal must contain the following information:

- Your name,
- Your address,
- Your member ID number,
- A summary of your appeal and any previous contact made with us,
- Any additional supporting documentation or medical records, and
- A description of the desired outcome.

The appeal must be signed, dated and mailed, e-mailed, faxed or delivered to:

Health First Health Plans and Insurance
Attn.: Appeals
6450 US Highway 1
Rockledge, FL 32955
Fax: 1.855.328.0053
E-mail: hfhpinfo@health-first.org

If your appeal relates to care or services you have already obtained, you will be notified of the outcome of your appeal in writing within 30 calendar days after it was received.

If your appeal relates to the denial of coverage for care you have not received and are waiting to obtain, you will be notified in writing of the outcome within 15 calendar days after it was received.

A one-time extension may be applied if additional information is necessary to make a decision on your appeal and you do not object to the extension. If this happens, the additional information will be requested within the resolution time frames. A decision will be made and communicated to you.

Expedited review of an urgent appeal: Either you, your authorized representative, or your treating provider may request an expedited review of your appeal if the standard time frame would seriously jeopardize your life, health or ability to regain maximum functioning. Appeals related to services already received are not eligible for the expedited process.

This request may be made verbally or in writing. We reserve the right to determine if the expedited process is warranted, but we will automatically grant the request for an expedited review if a physician supports it.

When the expedited appeal procedure is granted, you will be notified of the outcome as soon as your medical condition requires, but no later than 72 hours after we receive your request for an expedited review.

Authorized reviewers: An individual who has made a previous denial on your case will not be permitted to deny it a second time nor will any associate that reports to them. Appeals will be investigated by an Appeal and Grievance Coordinator and directed to the appropriate person with authority and clinical expertise to make a final decision. If the appeal involves a denial of coverage based on medical necessity, a physician with appropriate medical expertise will review the case and make a decision.

External review
Within four (4) months after receiving a final determination notice from the Health Plan regarding an adverse outcome of a first-level Appeal, you or your authorized representative have the right to request external binding review. External binding review is available for appeals that involve medical necessity or the determination of whether a service is experimental or investigational. There is no dollar limit on issues eligible for review, and there is no cost associated with this review.

If your medical condition warrants an expedited Appeal process (as determined by the Health Plan) expedited external review may be requested when an expedited Appeal is requested through the Health Plan (at any level of Appeal), and after the internal appeal process has been completed.

To request external review, you or your authorized representative must contact the Health Plan by writing to the address or calling the number below:

Health First Health Plans
Attn.: Appeals
6450 US Highway 1
Rockledge, FL 32955
Phone: 1.855-443-4735
Fax: 1.855.328.0053
E-mail: hfhpinfo@health-first.org

Eligibility requirements for external review:

1. You must be (or must have been) covered under the plan when the item or service was requested or rendered;
2. The appeal must not be related to your eligibility under the terms of the plan;
3. The appeal must be related to a medical necessity determination, or whether a requested item or service is experimental or investigational;
4. The internal appeal process must have been completed, or deemed completed by the Plan;
5. All information and forms required to process the independent review must be provided.

For standard external review requests, the Health Plan will complete a preliminary review of the request to determine if the Appeal is eligible for external review within 5 business days of receipt of the request. For expedited Appeals (as determined by the Health Plan), this preliminary review will be conducted the same day the request is received.

Assistance with concerns, grievances, and appeals

Members may request help with concerns, grievances, and appeals by contacting us. If you have questions about your plan or need assistance in a language other than English, please call Customer Service.

New technology

What are new technologies?

New technologies are medical and/or behavioral health services including treatments, procedures, and devices that have been recently introduced to the market and are still considered investigational or experimental. Some may have been recently approved for use by the Food and Drug Administration but not adopted yet as a “standard of care” in the medical community.

How are new technologies evaluated for inclusion in the benefit package?

The plan may receive requests from members and physicians for coverage of new technologies. While new technologies are always exciting and come with great expectations, it is not always clear that they will provide the most effective treatment options for patients.

The plan has a committee that evaluates new technologies to determine if they should be covered. The committee includes participating physicians from various specialties, medical directors, and staff pharmacists. We are committed to looking carefully at such services to be sure they are safe, helpful in treating or maintaining health, reasonably cost-effective, and not subject to being used for purposes other than those intended.

We consider the thoroughness of research behind the new service, clinical trial results, and the anticipated value to our members. We also research and evaluate literature and invite physicians requesting the service to present their findings before we make a decision. To ensure decisions are unbiased and made solely for the benefit of our members, the majority of committee members are not financially tied to the Health Plan, and any participating physician is welcome to participate in the process.

Quality program information

We are committed to providing quality, cost effective healthcare coverage. Our participating physicians and dedicated staff work together to improve care, service, and overall performance of our organization. We participate in a number of independent reporting organizations for quality of care and service to provide our members with information about the quality of care we deliver, as well as a way to compare our performance to other Health Plans in the area.

The quality reporting organizations we participate with include:

- The National Committee for Quality Assurance (NCQA) for Health Plan accreditation status.
- Healthcare Effectiveness Data and Information Set (HEDIS) for clinical effectiveness of health care measures of performance.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey to measure Health Plan member satisfaction.

The National Committee for Quality Assurance (NCQA) is a private, non-profit organization dedicated to improving healthcare quality. NCQA is the nation's "gold standard" for measuring managed care organizations.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90% of America's Health Plans to measure performance on important dimensions of care and service.

Healthy Living Program

We are committed to helping you reach your health and quality of life goals. We offer programs designed to help you stay healthy and fit, as well as a variety of programs to help you live better with serious chronic medical conditions.

Health in Motion
Fitness Center Membership is included at Health First ProHealth and Fitness Centers, Melbourne, Merritt Island, Palm Bay and Viera or with HealthWays Prime location nationwide. Amenities vary by location, but participating fitness centers are selected for their variety of group classes for all fitness levels, cardio and strength equipment and other features like pools, basketball and racquetball courts, walking and running tracks, and more. For more information on location and how to get started, visit myhfhp.org/fitness.

Enjoy Fitness Discounts by presenting your member Health First ID card and save!

- Running Zone: 10% discount on merchandise
- Running Zone's Race Series: save $5.00 off the registration fee for individual races
- Revolutions Cyclery: 10% discounts on parts, clothing and accessories
- Runners Depot: save 50% off the registration fee for individual races

Eat Well
Medical Nutrition Therapy Services for members at risk for cardiovascular or diet related chronic medical conditions, and followed by physician for Diabetes, Heart Disease, Kidney Disease,

Lipid Disorder, Malnutrition or Obesity. (Physician referral required)
Work with a Professional Lifestyle Coach to set and complete healthy eating goals, make changes that can last a lifetime, and track progress by phone or online.

No Stress Zone
Health First ProHealth and Fitness Centers offer 25% discount on massage treatments.

Clear the Smoke
I Quit and Quit Now classes are offered at Health First and Florida Hospitals and conducted by the Florida Area of Health Education Centers (AHEC) Network. Each class is a no cost, six session group program that includes nicotine replacement (while supplies last). For details visit HFevents.org or ahectobacco.com/calendar.
As our mental health benefits manager, Magellan Behavioral Health also offers a comprehensive package of online tools to break the smoking habit. Members can set up a secure account at MagellanHealth.com/Member to access tools and information.
Work with a Professional Lifestyle Coach to set and complete quit smoking goals, make changes that can last a lifetime, and track progress by phone or online.
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Stay Well
Preventive Health Screenings are encouraged and are offered at no extra cost. Preventive health screenings include vaccinations, adult well care visits, and preventive labs. Please make your appointment today with your physician.

Chronically Well
The chronically well program is available to empower you to take charge of your health under the supervision of your physician. The chronically well program focuses on the following five diagnoses using analytics and your preferences:

- Asthma
- COPD (Chronic Obstructive Pulmonary Disease)
- Coronary Artery Disease
- Diabetes
- Heart Failure

Health 360°
Health First Health Plans identifies complex needs using industry leading analytics. Our integrated care approach addresses physical, mental, and medication needs to assist you in attaining your optimal level of health. These programs include:

- Acute Care Management
- At Home Provider Visits
- Behavioral Health Care Management
- Biometric and symptom monitoring at home using state-of-the -art technology
- Care Alerts
- Complex Case Management
- Embedded Pharmacists and Case Managers within the Primary Care offices
- Medication Therapy Management and Specialty Programs
- Nurse 24 line
- Rehabilitation Care Management
- Transitions of Care Management
- Transplant Coordination

Please call Customer Service to find out more about our Health Living programs and if you qualify.

Identity & Fraud Protection

At Health First, we are always looking for opportunities to provide additional benefits that enhance your quality of life. That is why we recently partnered with AllClear ID, an industry leading firm to provide pre-paid access to identity theft protection and credit monitoring services.

This service is provided by Health First and comes at no charge to you.

Identity Theft Protection
AllClear Secure provides identity protection for you by investigating and repairing your identity in the event that it is stolen. They will do the work to recover your financial losses and restore your credit report.

Member rights & responsibilities

We value our relationship with you, and we believe that setting clear expectations about our partnership is a critical part of earning your trust. The following rights and responsibilities represent the cornerstone of our successful future, and we encourage you to become familiar with them.

As a member, you have the right:

- To receive these rights and responsibilities, as well as other information about your Health Plan and its benefits, services and providers.
- To be treated with respect and recognition of your dignity and right to privacy. (See our Notice of Privacy Practices section of this Guidebook for additional information on how we protect your information.)
- To participate with practitioners in decisions involving your health care, considering ethical, cultural and spiritual beliefs, unless concern for your health indicates otherwise.
- To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage. You have the right to receive this information in terms you understand.
- To receive a prompt response when you ask questions or request information.
- To be informed of who is providing your medical care and who is responsible for your care.
- To be informed if your health care provider plans to use experimental treatment for your care. You have the right to refuse to participate in such experimental treatment.
- To receive a reasonable estimate of charges for your medical care and a copy of an itemized bill, reasonably clear and understandable, and have the charges explained to you.
- To receive information about copayments and fees that you are responsible to pay.
- To know what patient support services are available to you, including whether an interpreter is available if you do not speak English.
- To be informed about your diagnosis, testing, treatments, and prognoses. When concern for your health makes it inadvisable to give such information to you, such information will be made available to an individual designated by you or to a legally authorized individual.
- To be informed about consent to treatment, your right to refuse treatment to the extent permitted by law, and the consequences of your refusal. When refusal prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the member may be terminated by the provider upon reasonable notice.
- To receive quality, timely health care with respect and compassion regardless of race, age, sex, religious beliefs, source of payment, health status, or need for health services.
- To determine the course of your treatment by issuing “advance directives.” In accordance with the federal law titled “Patient Self-Determination Act” and the Florida Statute Chapter 765 titled “Health Care Advance Directives,” you can make future health care decisions now with these types of advance directives:
  - The “living will” states which medical treatments you would accept or refuse if you became permanently unconscious or terminally ill and unable to communicate.
  - The “durable power of attorney for health care” or “designation of a healthcare surrogate” allows you to appoint someone else to make decisions regarding your health care when you are temporarily or permanently unable to communicate.
- To have your medical records kept private, except when you provide your consent or when permitted by law.
- To choose a primary doctor to coordinate your care and to change your doctor at any time.
- To receive information about our quality improvement programs including the progress being made.

- To make recommendations regarding our member rights and responsibilities policies.
- To receive information and necessary counseling on the availability of known financial resources for your care.
- To know what rules and regulations apply to your conduct.
- To voice concerns or file appeals about your benefits, our service, or the care provided.

Additionally, you have the responsibility:

- To understand your benefits and plan guidelines.
- To supply accurate and complete information, including unexpected changes in your health condition (to the extent possible) that your plan and your providers need in order to provide you care.
- To provide your primary doctor, to the best of your knowledge, accurate and complete information about any current medical concerns, past medical history and any other information relating to your health.
- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- To follow the plans and instructions for care that you have agreed on with your providers.
- To be responsible for your actions if you refuse treatment or do not follow your healthcare provider's instructions.
- To follow the provider's rules and regulations affecting patient care and conduct, including keeping your appointments, arriving promptly, and notifying your physician in a timely fashion if you are unable to keep a scheduled appointment.
- To pay your cost-share or any other applicable fees according to your plan documents.
- To notify us of any changes in your address, telephone number, or eligibility status.
- If you are enrolled in an HMO plan, to use participating primary care physicians, specialists, medical facilities and suppliers (except for emergency care).

Notice of privacy practices

This notice describes how your Protected Health Information (PHI) may be used and disclosed by the plan, and how you can access this information. Please review this notice carefully, and contact the Privacy Office at 321.434.7543 Monday through Friday 8a.m. to 5 p.m. or toll-free at 1.888.400.4512 after business hours.

Our pledge regarding your protected health information

Our greatest concerns are your health and privacy. We know how important it is to protect your privacy at all times and in all settings. Rest assured we are committed to using and disclosing this information responsibly. This Notice of Privacy Practices describes how the Health Plan may collect, use and disclose your protected health information, along with your rights concerning your protected health information.

What is protected health information?

"Protected health information" or "PHI" is information about you, including demographic information, that can reasonably be used to identify you and which relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care. For purposes of this notice, PHI means any information that is created or received by the Health Plan relating to your health or the provision or payment for your health care.

We are required by law to:

- make sure your protected health information is kept private;
- Notify you, in writing, in the event that your privacy has been compromised (breached);
- give you this notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the current notice in effect.

Federal law requires us to maintain the privacy of your protected health information. The Health

Insurance Portability and Accountability Act of 1996 (HIPAA) also requires us to provide you this notice about our legal duties and privacy practices. We must follow the privacy practices described in this notice while it is in effect. We may change the terms of this notice at any time. We must provide you a new Notice of Privacy Practices whenever we make a material change to the privacy practices described in this notice.

How do we protect your personal health information?

The Health Plan is committed to protecting your health information. All associates are trained annually and are required to protect the confidentiality of your protected health information. Individuals may only access information when they have an appropriate reason to do so. Any associate who violates organizational privacy policies is subject to discipline, up to and including termination. The Health Plan includes confidentiality provisions in all of its contracts with participating providers and vendors to ensure physical, electronic, and procedural safeguards are maintained to protect your information.

How we may use and disclose health information about you

The following categories describe the ways in which the Health Plan may use or disclose your protected health information. For each category, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed, but all of the ways we are permitted to use or disclose your information will fall within one of these categories.

For treatment: We may disclose your protected health information to healthcare providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with your treatment. We may also disclose your protected health information to healthcare providers (including their employees or business associates) in connection with preventive health, early detection and disease and case management programs.

For payment: We may use and disclose your protected health information to administer your healthcare policy or contract, which may involve:

- Determining your eligibility for benefits.
- Paying claims for services you receive.
- Making medical necessity determinations.
- Coordinating your care, benefits or other services.
- Coordinating your coverage with other plans.
- Responding to complaints, appeals and external review requests.
- Obtaining premiums, underwriting, rate making and determining cost sharing amounts.
- Disclosing information to providers for their payment purposes.

For healthcare operations: We may use and disclose your protected health information to support business activities for healthcare operations, which include some of the following activities:

- **Quality management:** Conducting quality assessment and improvement activities, such as improving our members' health or reducing healthcare costs, developing clinical guidelines and protocols, and activities necessary for accreditation.
- **Case management and care coordination:** Operation of preventive health, early detection and disease and case management including contacting you or your doctors to provide appointment reminders or information about treatment alternatives, therapies, health care providers, settings of care or other health related benefits and services.
- **Credentialing:** Reviewing the competence or qualifications of healthcare professionals by evaluating their performance.
- **Certification and licensing activities:** Activities necessary to maintain our required state licenses, accreditations and certificates, such as our Florida HMO and Third Party Administrator (TPA) licenses, in addition to our Florida Healthcare Provider Certificate.
- **Underwriting:** Underwriting, premium rating and other activities relating to administering health insurance contracts. Obtaining reinsurance and/or stop-loss insurance. Please note that all Health Plans are prohibited from using or disclosing genetic information for underwriting purposes.
- **Medical review, legal services, and auditing functions:** Includes activities

related to fraud and abuse detection and compliance programs requirements.
- **Business planning and development:** Data analyses related to operating the Health Plan, including formulary development and administration, development or improvement of payment and coverage policies.

Other General Administrative Activities: Includes, but is not limited to, data and information systems management and customer service.

Communicating Health Plan benefits and services: Informing you about your Health Plan benefits or services that may be of interest to you. Please note that we do not, under any circumstances, sell your protected information for marketing purposes.

Other Permitted or Required Uses and Disclosures of Protected Health Information:

To you: We will disclose your protected health information to you or your authorized representative upon request, except in limited circumstances. For a representative to act on your behalf, you must appoint them as your representative in writing, and provide the written appointment to the Health Plan.

To individuals involved in your care or payment for your care: We may disclose your protected health information to a friend or family member who is involved in, or helps pay for, your care. In addition, we may disclose your protected health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

As required by law: We may use or disclose your protected health information to the extent we are required to do so by federal, state, or local law. For example, HIPAA law compels us to disclose PHI when required by the Secretary of the Department of Health and Human Services to investigate our compliance efforts.

Public health activities: We may disclose your protected health information to an authorized public health authority for purposes of public health activities. The information may be disclosed for such reasons as controlling disease, injury or disability. We also may have to disclose your PHI to a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading the disease. In addition, we may make disclosures to a person subject to the jurisdiction of the Food and Drug Administration, for the purpose of activities related to the quality, safety or effectiveness of an FDA-regulated product or activity.

Abuse or Neglect: We may make disclosures to government authorities if we believe you have been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when we are required or authorized by law to do so.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal and, in certain cases, in response to a subpoena, discovery request or other lawful process.

To avert a serious threat to health or safety: We may use and disclose your protected health information to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Law Enforcement: We may disclose your protected health information under limited circumstances to law enforcement officials. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness or missing persons or to provide information concerning victims of crimes.

Organ and tissue donation: We may disclose your protected health information in certain instances to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ or tissue donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Workers' Compensation: We may disclose your protected health information to the extent required by workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

Will we give your PHI to your family or friends?

We will only disclose your PHI to a member of your family (including your spouse), a relative, or a close friend in the following circumstances:

- You have authorized us to do so.
- That person has submitted proof of legal authority to act on your behalf.
- That person is involved in your health care or payment for your health care and needs your PHI for these purposes. If you are present for such a disclosure (whether in person or on a telephone call), we will either seek your verbal agreement to the disclosure or provide you an opportunity to object to it. We will only release the PHI that is directly relevant to their involvement.
- We may share your PHI with your friends or family members if professional judgment says that doing so is in your best interest. We will only do this if you are not present or you are unable to make healthcare decisions for yourself. For example, if you are unconscious and a friend is with you, we may share your PHI with your friend so you can receive care.
- We may disclose a minor child's PHI to their parent or guardian. However, we may be required to deny a parent's access to a minor's PHI, for example, if the minor is an emancipated minor or can, under law, consent to their own health care treatment.

Will we disclose your PHI to anyone outside of your plan?

The Health Plan may share your protected health information with affiliates and third party "business associates" that perform various activities for us or on our behalf. For example, the Health Plan may delegate certain functions, such as medical management or claims re-pricing, to a third party that is not affiliated with us. We may also share your personal health information with an individual or company that is working as a contractor or consultant. The Health Plan's financial auditors may review claims or other confidential data in connection with their services. A contractor or consultant may have access to such data when they repair or maintain our computer systems. Whenever such an arrangement involves the use or disclosure of your protected health information, we will have a written contract that contains terms designed to protect the privacy of your protected health information. The Health Plan may also disclose information about you to your primary care physician, other providers that treat you, and other Health Plans that have a relationship with you for their treatment, payment and some of their healthcare operations.

When do we need your written authorization to use or disclose your personal health information?

We have described in the preceding paragraphs those uses and disclosures of your information that we may make either as permitted or required by law or otherwise without your written authorization. For other uses and disclosures of your medical information, we must obtain your written authorization. A written authorization request will, among other things, specify the purpose of the requested disclosure, the persons or class of persons to whom the information may be given, and an expiration date for the authorization. If you do provide a written authorization, you generally have the right to revoke it.

Your rights regarding your health information

You have the following rights regarding health information we maintain about you:

Right to inspect and copy: You have the right to inspect and receive a copy of your protected health information. This usually includes medical and billing records but does not include psychotherapy notes. To request this information, you must submit your request in writing to the Health Plan at the address located at the end of this notice. If you request a copy of the information, we reserve the right to charge a reasonable fee for the costs of producing and mailing the information associated with your request. The information will typically be provided within 30 days. We may deny your request in very limited circumstances. If you are denied access to your protected health information, you may request that the denial be reviewed. A licensed healthcare professional who did not deny your original request will

perform the review, and we will comply with the decision of that person.

Right to amend: If you feel that your protected health information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Health Plan. To request an amendment, you must submit your request in writing to the Health Plan at the address located at the end of this notice. You must provide a reason that supports the requested amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us (unless the person or entity that created the information is no longer available to make the amendment),
- is not part of the information kept by or for the Health Plan,
- is not part of the information which you would be permitted to inspect and copy, or
- is not accurate and complete.

Right to an accounting of disclosures: You have the right to request an accounting of disclosures of your protected health information that were unrelated to treatment, payment, or healthcare operations, or were not authorized by you. To request this accounting, you must submit your request in writing to the Health Plan at the address located at the end of this notice. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request before any costs are actually incurred.

Right to request restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. If we agree, we will comply with your request, unless the information is needed to provide emergency treatment. We are not required to agree to your request however. The Health Plan will not agree to restrict the use or disclosure of your health information for treatment, payment or healthcare operations, as these activities are essential to the services we provide you. To request restrictions, you must submit your request in writing to the Health Plan at the address located at the end of this notice**.** In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to request confidential communications: You have the right to request that we communicate with you about health information in a certain way or at an alternative location. For example, you can ask that we only contact you at work or by email. To request confidential communications, you must submit your request in writing to the Health Plan at the address located at the end of this notice**.** We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a paper copy of this notice: You have the right to a paper copy of this notice, and may obtain one by contacting the Health Plan's Customer Service Department 855.443.4735. You may also write to the address listed at the end of this notice or obtain one through our website, myhfhp.org. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Changes to this notice

We reserve the right to change this notice and to make the revised or changed notice effective for protected health information we already have about you as well as any information we receive in the future.

Complaints and communications

If you believe your privacy rights have been violated, you may file a complaint with the Health Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Health Plan, please write to the address listed at the end of this notice, or contact Customer Service. You will not be penalized or retaliated against for filing a complaint.

Other uses of health information

Uses and disclosures of protected health information not covered by this notice or other applicable laws will be made only with your written permission. If you provide us permission to use or disclose your protected health information, you may revoke that permission in writing at any time.

To contact us regarding this information, please write to us at:

Health First Chief Compliance Officer
Attn: Privacy
6450 US Highway 1
Rockledge, FL 32955

Advance directives

Under Florida law, every adult has the right to make certain decisions concerning his or her medical treatment. The law also allows for your rights and personal wishes to be respected even if you are too sick to make decisions yourself.

You have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment and other procedures that would prolong your life artificially. These rights may be spelled out by you in a "Living Will," containing your personal directions about life-prolonging treatment in the case of serious illness that could cause death.

You may also designate another person, or surrogate, who may make decisions for you if you become mentally or physically unable to do so. This surrogate may function on your behalf for a brief time, or longer for a life-threatening illness. Any limits to the power of the surrogate in making decisions for you should be clearly expressed. An accident or illness can take away a person's ability to make health care decisions, but decisions still have to be made. If you cannot do so, someone else will, and sometimes this causes the burden, delay and expense of court proceedings. You should consider whether you want to take steps now to control these decisions so that they will reflect your own wishes.

Living will

A Living Will or Declaration is a statement of your wishes regarding the use of life-prolonging treatment if you have a terminal condition. A Living Will is different from a will, which disposes of your property after your death. Generally, a Living Will is a statement that you desire to be allowed to die and not be kept alive by medical treatment when your doctors conclude that you are no longer able to decide matters for yourself and that your condition is terminal. If you would not want to be kept alive by use of a feeding tube or other artificial means of providing food and water, specifically state this.

Surrogate designation

If you are too sick to make decisions, close family members or a close friend usually will decide with the doctor and nurses what is best for you. A written designation of a health care surrogate establishes a rebuttal presumption of clear and convincing evidence of your designation of a person to make these decisions.

If you want to name someone you trust to make all other medical decisions for you when you are too sick to do so yourself, you may wish to put this in writing. Remember, if you want this person to also make decisions about the use of machines and medical treatment that might delay your death when you are hopelessly ill, name the same person in your Living Will. It is advisable to name a replacement in case the person you have chosen to make decisions for you becomes unable or unwilling to do so. If you decide to make a Living Will or other advance directive, you should give a copy to your doctor, your closest relative or friend, and any hospital, nursing home or other facility where you are receiving treatment or care. If you change your mind, please make sure that you advise all those to whom you have given copies.

A Living Will in no way affects life insurance. Also, it cannot be required as a condition for being insured for or receiving healthcare services. Any medical treatment that is used for the purpose of providing comfort care or to alleviate pain will be continued.

A summary like this cannot answer all of your questions or cover every circumstance. If you have questions about your particular legal

situation, please talk to a lawyer. Also, ask your family physician to assist you.

Exclusions & limitations

We try to keep Health Plan premiums affordable while providing the most comprehensive coverage possible. In doing so, certain limits and exclusions may apply to the benefits provided under your plan.

This section lists common exclusions and limitations under our Individual Health Plans. Your Evidence of Coverage will ultimately determine coverage, so please review it carefully. If the rules for accessing services and supplies described in this section are not followed, you risk being responsible for the entire cost of the services rendered.

Medical necessity requirements

Services that, in the plan's opinion, are not medically necessary will not be covered. The ordering of a service by a physician, whether participating or non-participating, does not in itself make such service medically necessary or a covered service. Whether a service is covered is determined according to the terms of your Individual policy as solely interpreted by the Health Plan or its delegate.

The following services and supplies are excluded from coverage:

Abortions, including any service or supply related to an elective abortion. However, spontaneous abortions are not excluded, nor are abortions performed when the life of the mother would be endangered if the fetus were carried to term.

Alcoholism or substance abuse treatment - in a residential treatment facility

Alternative medical treatments

Blood fees associated with the collection, storage, or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Health Plan's opinion the likelihood of excess blood loss is such that transfusion is expected adjunct to surgery.

Bloodless surgery, unless comparable outcomes, complication rates, and mortality rates are demonstrated through peer reviewed clinical studies when compared to standard surgical methods

Breast reduction services

Complications of non-covered services

Cosmetic procedures

Routine dental care, except for pediatric dental coverage under the Affordable Care Act

Food and food products, including oral nutrition supplements, except those listed as covered services under the Enteral/Parenteral and Oral Nutrition Therapy section of your plan documents.

Routine foot care, Hearing aids
Immunizations and physical examinations when required for travel, or when needed for school, employment, insurance, or governmental licensing, except as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements.

Infertility treatment, services and supplies

Massage therapy

Missed appointment charges

Obesity surgery
Exceptions may apply. See your Evidence of Coverage for details.

Occupational injury

Organ donor treatment or services when the member acts as the donor

Orthomolecular therapy

Orthotics, foot

Personal comfort items

Private duty nursing care
Provided by a physician or other health care provider related to the covered person by blood or marriage.

Sexual reassignment or modification services

Sterility reversal

Surrogacy services

Work-related condition services to treat a work-related condition, to the extent the covered service is paid by Workers' Compensation through adjudication or settlement, or when the services would otherwise be eligible for coverage by Workers' Compensation insurance but were not claimed, are excluded from coverage.

Glossary of terms

To help you better understand your Health Plan, we have listed important terms and their definitions for your review.

Adverse coverage determination: a decision on a claim is "adverse" if it is: (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a Plan benefit.

Allowable charge: The amount charged, or the amount the plan determines to be paid in accordance with our fee schedule, whichever is less, for a particular medical or hospital service in the geographical area in which it is performed.

Child: The term includes the subscriber's or covered spouse's natural born child, stepchild, foster child or legally adopted child upon placement in the subscriber's residence, provided proof of such guardianship is presented. In the case of the birth of a newborn adopted child, a written agreement to adopt such child has been entered into prior to the birth of the child.

Coinsurance: The portion of the cost for specified covered services for which the member is responsible. Generally, this is stated as a percentage of the allowable expense for covered services. Coinsurance amounts are included in the Schedule of Benefits.

Contract: The contract between the Health Plan and the subscriber that includes the Evidence of Coverage, application, and any riders, amendments, and attachments.

Copayment: A predetermined dollar amount listed in the Schedule of Benefits that the member must pay for certain plan benefits.

Covered services: The benefits and services to which a member is entitled.

Domestic partner: An adult of the same or opposite sex whom the Policyholder is in a Domestic Partnership.

Domestic Partnership: The relationship between the Policyholder and another adult of the same or opposite sex that satisfies all of the following criteria:

1. Are in a mutually exclusive relationship similar to marriage and intend to stay in that relationship for an indefinite period;
2. Take responsibility for one another's welfare;
3. Have not entered into the partnership for the primary purpose of obtaining health insurance;
4. Are eighteen (18) years of age or older and are capable to enter into contracts;
5. Are not blood relatives to the extent that would forbid them from being married in the state of Florida;
6. The Policyholder and partner are both not married, legally separated, or have been party to divorce proceedings or annulment in the last six (6) months; and
7. The Policyholder and partner are not currently registered in or have a domestic partnership with someone else, and if either has been in a previous domestic partnership, at least six (6) months have passed since the effective date of the termination of that registration or domestic partnership.

Eligible dependent: An eligible dependent is defined as one of the following:

1. The subscriber's lawful spouse.
2. The subscriber's domestic partner (as defined in the Glossary of terms section of this Guidebook).
3. The subscriber's, covered spouse's, or covered domestic partner's child who has not reached the end of the calendar year in which he or she reaches age 26.
4. The newborn child of a covered dependent child up to 18 months after birth of such newborn.

In addition, Florida law requires fully-insured plans to offer continuity of coverage for dependent children after the child turns 26 until the end of the calendar year in which he or she turns 30, if the child:

1. is unmarried without dependents of their own;
2. is a state resident, or a full or part-time student; and
3. is not provided coverage under any other group or individual insurance policy or entitled to Federal or State benefits.

Experimental and investigational treatment means any evaluation, treatment, therapy, or device which involves the application, administration or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by the Health Plan:

1. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health, and approval for marketing has not, in fact, been given at the time such service is furnished to the covered person;
2. Evidence considered reliable by the Health Plan showing that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I, or II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question;
3. Evidence considered reliable by the Health Plan and which shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question;
4. Evidence considered reliable by the Health Plan which shows that evaluation, treatment, therapy, or device has not been proven safe and effective for the treatment of the condition in question, as evidenced in the most recently published medical literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices.

Reliable evidence as defined by the Health Plan may include without limitation:

1. Reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;
2. Published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service including any of the National Institutes of Health, or the United States Office of Technology Assessment;
3. The written protocol or protocols relied upon by the treating physician or institution or the protocols of another physician or institution studying substantially the same evaluation, treatment, therapy, or device;
4. The written informed consent used by the treating physician or institution or by another physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
5. The records (including any reports) of any institutional review board of any institution that has reviewed the evaluation, treatment, therapy or device for the condition in question.

Medically necessary: Refers to health care services or supplies that a physician or appropriate practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are, as determined by the Health Plan:

1. provided in accordance with the generally accepted standards of medical practice;
2. considered safe and effective for the patients illness, injury or disease based on scientific evidence;
3. clinically appropriate, in terms of type, frequency, extent, site and duration:
4. not primarily for the convenience of the patient or physician; and
5. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patients illness, injury or disease.

In determining whether a service or supply is provided in accordance with generally accepted standards of medical practice, the following will be considered:

1. independent technology assessments from third-party vendors;
2. literature searches of peer-reviewed articles;
3. peer-reviewed, published research studies;
4. FDA standards;
5. Drug compendia recognized by the Health Plan;
6. Medicare National and Local Coverage Determinations;
7. Physician Specialty Society recommendations;

8. the views of physicians practicing in the relevant clinical area; and,
9. any other relevant factors.

Note: The fact that a physician prescribes, orders, recommends, or approves a service or supply does not, in itself, determine medical necessity or make the charge for such service or supply a covered benefit, even if not expressly excluded under this Health Plan.

Member: A subscriber or covered dependent, who meets the Health Plan's criteria for eligibility, is enrolled, and for whom the appropriate premium has been paid.

Out-of-area services: Those services provided outside the Health Plan's service area. For HMO members, covered benefits for out-of-area services are limited to urgent and emergency care, unless arranged by a Health Plan physician and authorized by the plans. If the member is an HMO member, all follow-up and continued care following urgent or emergent care must be obtained using a Health Plan participating provider.

Out-of-pocket expenses: Those medical expenses a member must pay because they are not covered under the Health Plan. These include copayments, ineligible charges, or any other limitation set forth in the plan documents.

Participating provider: A hospital, physician, pharmacy, or other healthcare practitioner or facility that has an agreement with the Health Plan to provide services to plan members.

Physician or **doctor:** Any person properly licensed and qualified to practice medicine pursuant to the law of the jurisdiction of the state of Florida including:

- Doctors of Medicine (MD) or Osteopathy (DO);
- Doctors of Dental Surgery (DDS) or Dental Medicine (DMD);
- Doctors of Chiropractic (DC);
- Doctors of Optometry (OD); and
- Doctors of Podiatry (DPM).

Primary care physician (PCP): A doctor who takes care of the primary needs of a patient. They practice one of the following: family medicine, general internal medicine, or pediatrics.

Prior authorization: Certain services require approval from the Health Plan before the service is rendered to guarantee coverage. Your doctor must submit a request to the Health Plan, along with all clinical information documenting the medical necessity for the services to be reviewed. In the event of an adverse determination where you disagree with our decision, you have the right to appeal the decision. Denials based on medical necessity are only rendered by licensed physicians.

Plan documents: Refers to the Evidence of Coverage provided to the member, which is governed by the laws of the State of Florida.

Service area: The zip code areas designated by the Health Plan where members must reside to be covered by this Health Plan.

Spouse: Any individuals who are lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages but who are domiciled in a state that does not recognize such marriages.