



# Member Guidebook

**Health First** | **HEALTH FIRST**  
**Health Plans**

*Inspiring healthy moments.*

FOR GROUP MEMBERS

# Member Guidebook



*Inspiring healthy moments.*

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## About this guidebook

This Member Guidebook contains important information about your health benefits plan offered through Health First Health Plans (HFHP). 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* or *Summary Plan Description* is considered your Plan Documents and will be your best resource for benefit information. You can view and print most Plan Documents online by registering with *MyHFHP* at [www.HealthFirstHealthPlans.org](http://www.HealthFirstHealthPlans.org). 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 HFHP 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

At [www.HealthFirstHealthPlans.org](http://www.HealthFirstHealthPlans.org). You will need to register through our secure portal, *MyHFHP* and then you may:

- 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 at 321.434.5665 or 1.800.716.7337 (TDD/TTY: 1.800.955.8771). Our Customer Service hours are:

- **Monday–Friday** from 8 am to 8 pm
- **Saturday** from 8 am to Noon.

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.*

If you speak a language other than English, representatives are available who speak several different languages. HFHP also uses over-the-telephone interpretation services in over 100 different languages. Members may also request translation of member materials.

### By email

Send you questions or comments to: [hfhpinfo@health-first.org](mailto:hfhpinfo@health-first.org).

### By fax

Send your fax to:  
321.434.4362

### By mail

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

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### **In person**

As the only local carrier in Brevard County, Health First Health Plans offers walk-in service Monday through Friday from 8 am to 5 pm. You don't need to schedule an appointment to visit us in person. However, if you have a sensitive or complex concern, it may be best to schedule a time when we can ensure you'll receive the attention you need. Our walk-in service is located at:

Health First Health Plans  
6450 US Highway 1  
Rockledge, FL 32955

### **Language access**

HFHP 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, Creole, 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 our provider directory for providers that speak other languages.
- Translated materials. Members can also request translations of your member materials. Call Customer Service to request a translation.
- 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 HFHP staff, you may be asked for your demographic information.

- At HFHP, 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. However, some employer groups may require that employees make address changes through the company's benefits department. Also, be sure to report any change that has occurred in your family status since your initial enrollment with HFHP, such as adding a dependent or newborn. These requests can be completed by submitting an Enrollment/Change form to your Benefit Administrator.

### **Other contact numbers**

For mental health/substance abuse treatment, call Circles of Care at 321.890.1550. Their hours of operation are Monday through Friday from 8 am to 4 pm.

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## How your benefit plan works

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### ***Your member identification card***

You will receive member identification (ID) cards listing your enrolled dependents. Keep it 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 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 at the Health First Health Plans (HFHP) website, or by calling Customer Service to speak with a representative.

### ***Types of plans***

#### **HMO Plans**

Your health benefits plan is a Health Maintenance Organization or “HMO” plan. HMO plans offer comprehensive health benefits, including preventive care services. Most members have a standard HMO plan, which means that you must use participating physicians and other health care providers to receive benefits for covered services. Except for emergency or urgent services, all services must be obtained from a participating provider.

#### **POS Plans**

One common variation of an HMO plan is a Point of Service (POS) plan. If you have a POS plan, your ID card will say “POS” on the front. Members with POS plans may choose to receive covered services from a non-participating provider any time he or she wishes. However, members generally receive a greater percentage of coverage by using participating physicians and providers. Keep in mind that certain services require prior approval regardless of the benefit plan you have. Please see the section called *Obtaining Covered Medical Care*.

#### **ASO Plans**

Some employer groups may select an Administrative Services Only (ASO) plan, sometimes referred to as Self-funded, Self-insured and/or Third Party Administrator (TPA) plan. With ASO plans, the employer funds the claim payments while only paying HFHP to administer the plan. Additional exclusions and limitations may apply with this type of plan. Be sure to read your Plan Documents.

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## Eligibility & enrollment

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### ***Who is eligible to enroll in HFHP?***

Health First Health Plans (HFHP) offers several types of plans, including options for local employers and their employees. If you live or work in our service area and qualify for one of these options, we welcome you to explore the advantages of Health First Health Plans.

#### **Eligible employees**

If your employer is a “small group” (2–50 eligible employees) you must first satisfy your employer’s waiting period. You must also work an average of 25 or more hours a week to enroll. Employees of “large groups” (51+ eligible employees) typically have specific rules around plan eligibility. Contact your Human Resources Department for details about your plan’s eligibility guidelines.

#### **Eligible dependents**

An eligible dependent is defined as the employee’s lawful spouse, and/or the employee’s child until the end of the Calendar Year in which the child reaches age 26.

The federal 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:

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- a) is unmarried,
  - b) is a state resident, or a full or part-time student;
  - c) is not provided coverage under any other group or individual insurance policy or entitled to Federal or State benefits.
  - d) is a member of an HMO or POS plan. ASO, TPA, self-funded or self-insured plans are not considered HMO plans. To inquire whether extended dependent eligibility coverage is applicable to your benefit plan, check with your employer, or your Plan Documents.

The term **child** includes the employee's natural born child, stepchild, foster child or legally adopted child of the employee upon placement in the employee'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.

#### **Service area**

Health First Health Plans' service area includes all of Brevard County and the city of Sebastian in Indian River County (zip codes 32957, 32958 and 32978). All group members must work or live in this service area.

#### ***How do I enroll in HFHP?***

##### **Employer group health coverage**

If Health First Health Plans is offered to you by your employer, you may select one of our plans when you first become eligible. Your Human Resources Department will typically handle your enrollment activities, providing you with forms, Plan Documents and collecting any premium payments you may owe. You may have an initial enrollment period, an annual enrollment period, and special election periods for qualifying events. We coordinate enrollment with your employer, and will communicate with you when necessary along the way. If you have questions about your eligibility or how to enroll, your Human Resources Department is usually the best source of information and should be contacted first for assistance. Feel free to contact us if you have any questions about your membership.

#### **Sole proprietors**

If you're the sole proprietor of a business located in our service area, and you live or work in our service area, you may be eligible for a guaranteed-issue policy. The month of August is currently the only open enrollment period for "one-life groups," with coverage becoming effective October 1 of the same year. There are several affordable plans designed just for the needs of our local small business owners, so call us in early August to see if you qualify for these special offerings.

#### ***How do I enroll my newborn child?***

During your pregnancy, there are many things you are doing to prepare for the birth of your child. Understanding how exciting and exhausting it can be to add a new child to your family, we encourage you to be as prepared as possible. One item you can add to your list is 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.

#### **HMO and POS Plans**

A newborn child will be covered from the date of birth as long as you notify both Health First Health Plans and your Human Resources Department within 31 days of birth. If you do not notify us in writing within 60 days of your child's birth, you will not be able to add your child to your policy until your employer's next open enrollment period. Be sure to notify us in writing within 60 days from the date of birth to ensure your child has coverage. Feel free to contact our Customer Service department for assistance.

#### **ASO Plans**

If you're enrolled in an ASO, TPA, self-funded or self-insured plan that contracts with Health First Health Plans, please check with your Human Resources Department or refer to your Plan Documents for details on how to add your newborn.

#### ***How do I enroll other dependents?***

Eligible dependents can be included when you

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initially enroll, during your open enrollment period, or within 31 days after a qualifying event. An example of a qualifying event is the loss of other group health insurance without the ability to replace it. Dependent children may be enrolled within sixty (60) days of losing eligibility for Medicaid or a Children's Health Insurance Program (CHIP) or if they become eligible for premium assistance under Medicaid or CHIP. There are other special circumstances that qualify for special election periods. Your Human Resources department will be able to assist you with this.

### ***When does my coverage end?***

We hope that you will never have to cancel your membership. But, there may be certain circumstances where you may need to select a new health benefits plan. As with the enrollment process, there are certain times when you become ineligible or can end your coverage. Since your employer may provide specific times when you may change or discontinue your coverage, please contact your employer's Benefit Administrator or reference your Plan Documents for details.

You may rest assured that HFHP cannot cancel your membership for reasons of health, regardless of your medical situation. Only the following situations can cancel you or your dependent's membership:

- Your employment ends. Your coverage termination date will be determined by your employer.
- Your employer's contract with Health First Health Plans ends.
- You or your dependent no longer meets eligibility requirements.

Coverage may also be terminated for the following reasons:

- If an HMO member relocates outside Health First Health Plans' service area, and a Point of Service option is not available through their employer.
- A member provides false or incomplete information affecting eligibility or plan administration. In this event, coverage will be canceled and the member will be responsible for all expenses related to the material misrepresentation.

- A member uses or permits 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 the member will be responsible for all expenses resulting from the misuse.
- A member's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative to the extent that their continuing membership seriously impairs Health First Health Plans' ability to furnish service to the member or other members.

### ***What are my options if my coverage ends?***

If your coverage ends through your employer, you may be eligible to enroll in a continuation policy, which allows you to remain on your group's plan by paying the premiums yourself. As allowed by federal or state law, this option is available to you if you become unemployed, self-employed or working in a job that does not offer medical coverage. This option is also available if you take a new job offering medical coverage that excludes Pre-Existing conditions. In addition, your spouse or dependent children are also eligible for continuation of coverage. Contact either your employer or HFHP if you need continuation of coverage or additional information on your options. Your employer may be obligated under a federal law known as COBRA to provide this information and cover you if you elect to pay the appropriate premium. You also have an option to convert to a non-group coverage plan by paying the premium yourself. Conversion plans and rates are approved by the State of Florida, however benefits may not be exactly the same as those you are currently receiving from your group. To request a conversion plan, you must notify HFHP immediately following termination from your employer.

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## **My financial obligations**

### ***What will my expenses be with Health First Health Plans (HFHP)?***

Every plan is different, and your financial obligations will vary based on your specific plan. You are responsible for your premium, along with any cost sharing your plan requires. Additionally, some medical services may not be covered by your plan. If you choose to obtain services that are not covered by your plan, you will be financially responsible if you choose to obtain them. Make sure to familiarize yourself with the benefits provisions, exclusions and limitations of your plan *before* you seek services so you don't incur unnecessary or unexpected expenses. To verify the cost sharing you will have for specific services, check your Schedule of Benefits for details, or you may contact us for assistance. Keep in mind that using participating providers and preferred drugs will help reduce your expenses significantly.

### ***What is a deductible?***

If required by your plan, a deductible is a set dollar amount that you must pay for medical services each year before your health plan starts paying your benefits. Once you satisfy your individual or family deductible requirements, your medical care will be covered according to the terms of your plan. A new deductible must be met every Calendar Year.

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

This important feature protects you from catastrophic medical expenses by limiting how much you have to pay during the calendar 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 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. See your Plan Documents for details.

### ***What is the difference between a copayment and coinsurance?***

Copayments and coinsurance are different types of member cost sharing, and 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 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 maximums to "essential" benefits. However, the law does not prohibit annual maximums on non-essential benefits.

### ***Are there limits for pre-existing conditions?***

If your plan includes a pre-existing condition clause, coverage for treatment of pre-existing conditions may be excluded for up to 12 months (up to 24 months for groups with only one eligible employee). This pre-existing condition exclusion period may be eliminated or reduced if you had "creditable coverage" prior to enrolling with Health First Health Plans. Note: Sixty-three days is the maximum you can have a break in coverage. Maternity is never considered a pre-existing condition for groups with two or more employees.

If limitations for pre-existing conditions apply to you, see your Plan Documents for more information.

### ***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

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Health First Health Plans' participating provider. Your Plan Documents show your share of the cost for receiving services both in and out of our network. It also shows an "out-of-network fee schedule," which determines the maximum amount we will pay for your out-of-network services. **If your provider charges more than the fee schedule allows, you will be responsible for paying that extra amount in addition to the applicable cost-share amount.**

Since your cost depends on whether the provider participates with us, you can save money by seeing Health First Health Plans' providers whenever possible. Actual costs will depend on the benefit plan you have, the providers you see, and the services you receive, but here's an example to help explain POS benefits.

**If you're seeing a participating physician**, we have a contract in place — we've already negotiated discounted rates, so your costs are based on that discounted rate. For example, a provider may normally charge a \$100 fee for an office visit, but we have a contract that sets the fee at \$80 for our members. If your coinsurance is 20%, you simply pay 20% of the \$80, which is \$16, and we pay the remaining \$64.

**If you see a physician who is *not* part of our provider network**, we may not have a contract in place. For example, if an out-of-network provider charges \$100 for an office visit, and we set \$80 as the maximum allowable charge, we would pay 80% of the \$80 allowable charge, which is \$64. Since the provider charged \$100 and we paid \$64, you would be responsible for the remaining \$36.

However, some out-of-network providers may agree to accept our fee schedule if you ask them in advance. This may limit your out-of-pocket expenses.

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, contact Customer Service or visit our website.

Remember that regardless of whether you use participating or non-participating providers, some services require prior authorization. Your physician will have this information or you may contact Customer Service.

*When seeking out-of-network services we encourage you to talk with your provider in advance and ask if they will accept our fee schedule. Often providers will agree, and you can save a lot of money.*

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## Doctors and other providers

### ***Can I choose my own doctor?***

Yes! For most medical care covered under an HMO plan, 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, Health First Health Plans (HFHP) does not require you to select a Primary Care Physician (PCP), but it's still important to establish a relationship with a doctor for your preventive and primary care and to coordinate any specialty care you may need.

Many services today are offered by physician assistants, nurse practitioners, or others who are not licensed as physicians. These services are rendered in accordance with Florida regulations, and usually 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

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patients. It also lists other participating providers like hospitals, outpatient surgery centers, pharmacies, labs, etc.

If you need a Provider Directory, visit our website or call us to request one. You can also contact Customer Service for additional information on doctors' professional qualifications. If you aren't sure which physician to choose, friends and family are often the best source of information. Ask them for recommendations to find one that is best for you.

### ***Can I change my doctor?***

Yes, you can change your doctor at any time for any reason. If you are an HMO member, simply choose another doctor from our participating provider network and schedule an appointment. Request that your previous provider transfer your medical records so your new doctor has all the information needed to care for you. They may ask you to sign a Medical Release form. Although it is not required, we do ask that you notify us when you change your doctor.

## **Obtaining covered medical care**

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### ***How do I get medical and behavioral health care?***

The way you obtain routine medical care will depend on the type of plan you have.

**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 Health First Health Plans (HFHP) 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 HFHP so you

don't incur charges for services that may not be covered.

If you have a POS plan, you may see non-participating providers but your costs may be higher than if you had received the services in-network from contracted providers. These types of plans offer more choices in the delivery of health care, but typically include higher premiums and out-of-pocket costs.

Regardless of which general type of plan you have, benefits and cost-sharing requirements will vary depending on the plan you're enrolled in. Be sure to check your Summary of Benefits, visit our website or contact us to determine if services are covered.

**Primary care** — To access primary care, simply contact your doctor to make an appointment. For after-hours care, you can also call your doctor's answering service 24 hours a day for instructions. You may be directed to an urgent care center or emergency room, or to make an appointment when your physician's office is open.

**Emergency care** — If you have a medical emergency, have someone take you to the closest emergency room. If you cannot get to the emergency room safely and quickly, call 911. Be sure to show your HFHP member ID card. If you're admitted to the hospital or need help coordinating your care after you are stabilized, have someone contact HFHP and your local doctor 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. They are listed in your Provider Directory and on our website. Avoiding unnecessary trips to a hospital emergency room can save you time and money. 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.

If you're outside the service area, you're covered for unforeseen illnesses or injuries that need to

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be treated before you return. Simply locate an urgent care clinic or other physician for the initial treatment, and contact your local doctor to obtain any necessary follow-up services. 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 by contact us for assistance.

**Hospital care** — If you need to be hospitalized and it's 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 your doctor will know if that's necessary and can take care of it for you.

**You *never* need authorization for emergency care at *any* hospital**, but if you are admitted to a *non-participating* hospital as part of your emergency care, please have someone contact us at 321.434.5665 or 1.800.716.7737 so we can help coordinate your care after you are stable.

**Mental (behavioral) health services** — Mental health services can be accessed directly without a physician referral as with other specialty care. If you're enrolled in an HMO plan, you can arrange for the appropriate services by calling Circles of Care directly at 321.890.1550. A mental 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, HFHP does not require members to get a referral to see *participating* specialists for covered services. However, some specialists may require you to be referred by 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 physician has information and will assist you by contacting us for services that require prior authorization.

Also, remember that referrals and prior-authorized services are still subject to any exclusions you may have for pre-existing conditions.

*Check a current Authorization List to ensure your coverage applies and you don't incur any unexpected expenses for services that may not be covered. You can get the Authorization List from our website or by calling us.*

For POS members, we require certain services to have prior authorization to be covered. A few examples that require prior authorization include MRI, PET, CT scans and nuclear cardiology studies, and there may be other services that must also be authorized. If you're using a provider who doesn't participate in the Health First Health Plans network, including our contracted national providers, please be sure you discuss the authorization process with your provider, notify HFHP, 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 contact our Customer Service department for additional information.

### ***What if I need a second opinion?***

If you would like to get a second medical opinion to review your current treatment plan, confirm a diagnosis, or for any other reason, please contact us to help you set up an appointment. If we require you to get a second opinion, all charges related to that second opinion will be covered in full.

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## Prescription drugs

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

Health First Health Plans (HFHP) maintains a Formulary, which is a list of medications approved by your plan. The Formulary lists drugs in tiers — your share of the cost depends on what tier your drug is in. When you need a prescription you should review this list with your doctor to find the most effective and lowest-cost alternative for you. Remember, prescriptions are also subject to any exclusions you may have for pre-existing conditions.

The Formulary is periodically updated by the pharmacists, physicians and other professionals on HFHPs' Pharmacy & Therapeutics Committee to ensure that you have access to a broad range of drugs at affordable prices, and is subject to change without notice. Any updates to the Formulary are communicated in *Healthy Living*, your quarterly member newsletter.

For a current copy of your Formulary, call us or visit our website.

### ***How do I request coverage for drugs that require prior authorization or are not on my Formulary?***

Certain medications must be reviewed for medical necessity to determine if they are eligible for coverage. If a covered medication you need requires prior authorization, your doctor should fax an authorization request with supporting medical information to our Pharmacy Department at 321.434.4752. We'll review urgent requests as soon as possible, and notify your doctor of our decision within 24 hours after receiving the necessary information. Allow up to 14 days for routine requests. Also, remember that prescription exceptions and prior-authorized drugs are still subject to any exclusions you may have for pre-existing conditions. Certain drugs are not covered by HFHP under any circumstances, but you do have the right to file an appeal if your request for coverage of an excluded drug is denied. Please see the section on Concerns and Appeals for information on

how to request a reconsideration of any coverage denial.

### ***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. HFHP 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 generic or Tier 1 medications whenever possible.**  
Generic drugs are the therapeutic equivalent of brand-name drugs, and are just as effective in most cases. Generic drugs generally cost less, so ask your doctor if switching to a generic equivalent of any brand-name drug you are taking is appropriate. In addition, Tier 1 drugs in many of our prescription drug riders are available for a very low copayment to ensure you have affordable access to many commonly prescribed medications. Please see our Formulary for information on which drugs are included in Tier 1.
- **Consider using the mail order program 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, call us or visit our website.
- **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 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

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proper dose — and save up to 50 percent of the cost. See your Formulary for more information.

- **Shop around for the best price.**  
Most of our prescription coverage comes with a fixed copayment, so your share of the cost would be the same at any of our participating pharmacies. But, 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 also change from day to day. Don't hesitate to contact the pharmacies in your Provider Directory to ask how much your medication will cost if you purchase it there.

### ***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. If you are due a reimbursement, simply send your detailed pharmacy receipt to us along with a written reimbursement request. Be sure to identify yourself and include your member ID number for reference. Although it is not necessary, you can also obtain a Prescription Drug Reimbursement Form by calling us or visiting our website at [www.HealthFirstHealthPlans.org](http://www.HealthFirstHealthPlans.org). Your reimbursement request should be sent to:

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

Send original documents, but keep copies for your own records.

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## **Claims**

### ***How do I get reimbursed for medical expenses?***

You should rarely need to file a claim since Health First Health Plans' (HFHP) 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 30 days. If reimbursement is denied for any reason, you will receive an Explanation of Benefits (EOB) that explains why. Please send your reimbursement request to:

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

Send original documents, but keep copies for your own records.

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

### ***Coordination of benefits***

Some HFHP members are also covered under another health plan – for example, the plan in which a spouse may be insured, Workers' Compensation or No-Fault, Personal Injury Protection. If that is true in your case, please be sure that you file your claims with your primary insurer – the insurer with whom you, yourself, have a contract or certificate of coverage. If the reimbursement you receive is less than the full

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charge for the service you are claiming, you can submit a claim to a secondary insurer – the insurer that covers you as a dependent or spouse of the person who has the contract or certificate of coverage with that plan. Please check your Plan Documents for details on how Coordination of Benefits (COB) works.

### ***What if I don't agree with the decision on my claim?***

If you don't 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 to:

Health First Health Plans  
Attn: Member Advocate  
6450 US Highway 1  
Rockledge, FL 32955

Or fax to 321.434.4362 within the time frame stated on your denial notice. You can also refer to the section called *Concerns, grievances, & appeals* for more information.

## **Concerns, grievances, & appeals**

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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 that we are committed to working with you personally to find a resolution if this happens, as well as providing you with timely, fair processes to have your concern addressed. Health First Health Plans (HFHP) offers informal concern and grievance processes, and also a two-step 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 either by phone or in our office. Simply contact us with any **concern**. You can do this by phone, in person, or in writing, and we'll provide you with immediate and active assistance. We'll make every attempt to resolve the problem within three days, and document your concern for quality improvement purposes.

### ***Grievances***

If you don't like the result of the concern process and you'd like us to reconsider, or if you'd rather not discuss your problem with a Customer Service Representative, you may also file a **grievance** with our Member Advocate. Just give us a description of the issue and how you would like it resolved. If you do this in writing be sure to sign and date it. We can help you if you need assistance.

You can mail, deliver, or fax your grievance in writing, or visit our office to speak with us:

Health First Health Plans  
Attn.: Member Advocate  
6450 US Highway 1  
Rockledge, FL 32955  
Fax: 321.434.4362  
8 am to 5 pm, Monday–Friday

You can also call our Customer Service department Monday through Friday from 8 am to 8 pm. Please leave a message and your call will be returned the next business day.

### ***Appeals***

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 year. Timeframe may be different for self-funded plans. Your appeal must contain the following information: your name, address and member identification 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

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outcome. The appeal must be signed, dated and mailed, faxed or delivered to:

Health First Health Plans  
Attn.: Member Advocate  
6450 US Highway 1  
Rockledge, FL 32955  
Fax: 321.434.4362

If your appeal relates to care or services you have already obtained, you will receive an acknowledgment within five business days. After a Member Advocate coordinates the investigation of your appeal, you will be notified of the outcome in writing within 30 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, a Member Advocate will coordinate the investigation of your appeal and will notify you in writing of the outcome within 15 calendar days after it was received.

One 15-day 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 listed above, and we will wait no longer than 45 days for the information to be received. A decision will be made and communicated to you within 15 days after the information is received, or when the 45-day period has elapsed.

**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 a Member Advocate 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.

**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. This

request may be made verbally or in writing. Health First Health Plans reserves the right to determine if the expedited process is warranted, but will automatically grant the request for an expedited review if a physician supports it. Appeals related to services already received are not eligible for the expedited process.

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.

### **Second level of review**

If you aren't satisfied with the outcome of the first level review of your appeal, you have the right to have your concern addressed by HFHP's Member Assistance Panel, consisting primarily of individuals who were not involved in any previous decision on your case. You or your authorized representative can request a hearing with the Member Assistance Panel verbally or in writing, but must do so within 180 days of receiving the first-level decision.

Your hearing will be scheduled at the administrative offices of HFHP or a location reasonably convenient to you. You or your authorized representative can attend the hearing in person, by teleconference, or through any other available technology. You will be afforded sufficient time to present your case and provide any additional information you would like considered, and the panel will ask questions and clarify the facts before adjourning for deliberation.

If your appeal relates to care or services you have already obtained, a Member Advocate will schedule a hearing with the Member Assistance Panel within 25 calendar days of your request unless you ask for a reasonable delay. If your appeal relates to the denial of coverage for care you have not received and are waiting to obtain, a Member Advocate will schedule the hearing with the Member Assistance Panel within 10 calendar days of your request unless you ask for a reasonable delay. If your appeal warrants an expedited process, we will schedule a hearing as quickly as appropriate to ensure you receive a final decision within 72 hours after your appeal request.

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A Member Advocate will notify you of the hearing with the Member Assistance Panel's decision within five business days after the hearing.

**External review:** If your employer offers a fully-insured, state-regulated plan, you have the right to appeal at any point in this process to the Department of Financial Services Division of Consumer Services, the Agency for Health Care Administration or its Subscriber Assistance Program. The request for appeal must be made within 365 days after receipt of the final decision letter from HFHP.

Florida Department of Financial Services,  
Room 319.7  
200 East Gaines Street  
Tallahassee, Florida 32399-0327  
1.877.693.5236

Subscriber Assistance Program  
Division of the Agency  
for Health Care Administration  
2727 Mahan Drive  
Building 1, Mail Stop 26  
Tallahassee, FL 32308  
1.888.419.3456  
850.921.5458

You may inform the Agency for Health Care Administration of any unresolved issue by calling their toll-free number. However you must complete HFHP's appeal procedure before you can be heard by the Subscriber Assistance Program.

### **Assistance with concerns, grievances, and appeals**

Members may request help with concerns, grievances, and appeals by contacting Customer Service or a Member Advocate. If you have questions about your plan or need assistance in a language other than English, please call Customer Service at 321.434.5665 or 1.800.716.7737 Monday through Friday from 8 am to 8 pm. For TDD/TTY relay, call 1.800.955.8771 during the same hours. Automated services are available around the clock.

If you speak a language other than English, representatives are available who speak several

different languages. HFHP also uses over-the-telephone interpretation services in more than 100 different languages.

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## **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, but 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?***

Health First Health Plans (HFHP) frequently receives 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. We're 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.

HFHP has a committee of participating physicians from various specialties, as well as medical directors and pharmacists on our staff whom evaluates new technologies to determine if they should be covered. 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.

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## Quality program information

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At Health First Health Plans (HFHP), 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.
- Centers for Medicare & Medicaid Services (CMS) STARS Program.
- J.D. Power and Associates.

The National Committee for Quality Assurance (NCQA) ranked Health First Health Plans #20 in the nation among Medicare Advantage Plans in 2010. NCQA is the nation's "gold standard" for measuring managed care organizations. In addition, we have received the highest accreditation status of "Excellent" for our commercial and Medicare products from NCQA in 2006 and 2009. To see the complete report card, visit [www.ncqa.org](http://www.ncqa.org).

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

The Centers for Medicare & Medicaid Services (CMS) recognized Health First Health Plans with 4.5 out of 5 stars in overall plan rating in 2010 on [www.medicare.gov](http://www.medicare.gov). Plan performance summary star ratings are assessed each year and may change from one year to the next. Although our Medicare Advantage plan is not a group plan, we don't distinguish different procedures from one plan to the next. Therefore, all of our members receive the same quality.

J.D. Power and Associates recognized HFHPs' Call Center for providing "An Outstanding Customer Service Experience" four years in a row (2008–2011).

To find out more about our quality programs, contact our Customer Service department.

*The National Committee for Quality Assurance (NCQA) is a private, non-profit organization dedicated to improving healthcare quality. Health First Health Plans ranked #20 among Medicare Advantage Plans by NCQA Health Insurance Rankings (2010-2011) and #80 in Private Plans making HFHP the second highest ranked plan in the state of Florida. All rankings are displayed at [www.ncqa.org](http://www.ncqa.org). For J.D. Power and Associates 2011 Call Center Certification Program information, visit [www.jdpower.com](http://www.jdpower.com). Health First Health Plans received a 4.5 out of 5 stars on an Overall Plan Rating from the Centers for Medicare & Medicaid (CMS). CMS plan ratings information is available online at [www.medicare.gov](http://www.medicare.gov).*

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## Health improvement programs

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### ***Do you have programs that can help me improve my health?***

Absolutely! There is nothing more important to us than your good health. Health First Health Plans (HFHP) offers 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.

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### **Pro-Health & Fitness membership**

For subscribers and enrolled dependents age 13 and older, membership at Pro-Health & Fitness Centers is included as part of your benefit plan\* — at no additional cost! And even if your dependents aren't covered by HFHP, they can enjoy discounted enrollment and membership fees at Pro-Health. Plus, HFHPs' members can enjoy a 25 percent discount on massage treatments!

As Brevard's premier fitness center, Pro-Health features:

- indoor pools, tracks, basketball and racquetball courts
- strength and cardio equipment
- a variety of classes for swimming and water aerobics, group cycling, group fitness (aerobics, yoga, pilates, spinning, etc.), and wellness
- weight management classes with a registered dietician
- locker rooms with saunas, steam rooms, and whirlpools
- and more!

Services and facilities may vary by location. For more information about Pro-Health, call

- Melbourne — 611 E. Sheridan Road  
321.434.7149
- Merritt Island — 255 Borman Drive  
321.434.5801
- Palm Bay — 5270 Babcock Street NE  
321.722.5943
- Viera — 8705 N. Wickham Road  
321.434.9149

*\* For HFHP members age 13 years and older, Pro-Health membership is part of fully-insured plans. Membership may not be included with self-funded plans — check with your benefits administrator or HFHP Customer Service for details. Monthly KidFit (child care) fees apply for children ages 12 years and younger. If you're already a member of Pro-Health, you must contact the fitness center to update your records and adjust your account to reflect your free or discounted membership. The new rate will be effective the first day of the month after you have completed the paperwork at Pro-Health, regardless of when you're eligible for this benefit. Pro-Health cannot issue any credits or refunds.*

### **Running Zone discounts help you take the first step towards better health**

Present your member ID card at *Running Zone* 321.751.8890 and receive a *10 percent discount* on merchandise, and discounts for the Running Zone Race Series. Located in a couple of places around the county, Running Zone has everything you need to help you get started with a walking, running, or triathlon training program. Running Zone will help you take your existing routine to the next level.

### **Health management**

When it comes to your health, sometimes you need more information and a little support making a decision. And sometimes you just need someone to talk to one-on-one about how to live a healthier life—in body and mind.

### **Health Coaches**

HFHP offers access to a personal Health Coach, at no additional cost—by phone, email, or chat 24 hours a day, 7 days a week. A Health Coach is a trained, healthcare professional who can provide you with one-on-one information on a variety of health issues, help you monitor your health needs, and help you work more closely with your doctor.

Health Coaches can also help you identify incremental goals to sustain long-term behavior changes in the following areas:

- Weight (BMI) Maintenance
- Smoking / Tobacco Cessation
- Physical Activity
- Healthy Eating / Nutrition
- Managing Stress

You can:

- Talk with a Health Coach anytime, day or night. Just call 1.800.308.5848 to speak with a knowledgeable and caring healthcare professional such as a nurse, dietician, or respiratory therapist.
- Receive personalized check-in calls or communicate by email with a Health Coach. You can talk to a Health Coach about your upcoming appointments, medications, diet, or exercise plan.

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- Get additional health information mailed to your home at no cost.
  - Learn about new techniques to help you take control of your health or specific conditions.
  - Use online services featuring 24/7 access to health and decision support tools. Just visit *MyHFHP* on our website to get started.

### **Other online health management services**

There are many other health management services you should take advantage of by using *MyHFHP*. This information is available 24/7 and is designed to empower you to be more accountable for your own health. Through our Healthy Living program, our online module, you may sign up for interactive reporting tools with points to be tracked and incentives to be earned—all to show the progress you are making along the way.

### ***Disease Management***

Click on the *MyHFHP* link to access up to date health information for you and your family. You can take the Health Assessment to learn about your own health risks and what you can do to lower them. You can also access in-depth information on more than 1,900 health topics including medical tests and medications. There are also many videos and DVD's available to you at no charge on conditions such as breast cancer, prostate cancer, back pain, and osteoporosis.

Need someone to talk to about a health issue? Call a Health Coach at 1.800.308.5848 for caring support from someone who will take the time to listen to your concerns and answer your questions. They are ready to assist you with general health information, support on managing a chronic illness, or help with a weight loss or nutritional program designed for you. A Health Coach may reach out to you if you have:

- Diabetes
- Heart Disease
- Congestive Heart Failure
- Asthma
- Coronary Artery Disease
- COPD

### ***Complex Case Management***

For our members coping with complex or serious medical conditions, a life-changing accident, or experiencing frustration or roadblocks in trying to get the care they feel they need, HFHP offers a personal RN-Case Manager to work one-on-one with you and your family or caregivers to help navigate the sometimes confusing world of healthcare. These highly trained and professional nurses work closely with your medical team to make sure you understand your condition, the best treatment options available, and how to connect with any support you may need during this challenging time in your life. We have highly skilled social workers available to assist with community resources or financial problem solving as well.

Members undergoing transplants, cancer treatments, or any other complex medical condition are appropriate for this service. Please contact customer service to access our Complex Case Management services.

### ***Care Level Management***

#### **Transition Program**

If you or your family member are very ill and are unable to get to their doctor's appointments, HFHP partners with a company called to offer Care Level Management. Members meeting requirements for this program have access to a doctor on call 24 hours per day, 7 days per week. Doctors and Nurse Practitioners come to the member's home and are able to provide medical care, many times preventing Emergency Room visits. Our Care Level Doctors work closely with the member and their family or caregivers, doctors, and our health plans staff to help keep the member in the best possible health and teach them how to cope with their illness.

#### **Transition Program**

Some medical conditions are known to cause frequent trips to the hospital. Members who are hospitalized with one of these conditions may qualify for the Transitional Program. Care Level Management reaches out to these members within the first week after discharge to see if extra care from a doctor in the home might help them to understand their medicines, discharge

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instructions, and illness. Some of the illnesses that would qualify someone for Care Level include Congestive Heart Failure, Heart Disease, and Diabetes.

Please contact Customer Service to see if you qualify.

## Member rights & responsibilities

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We value our relationship with you, and 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 Health First Health Plans (HFHP) 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 receive treatment for any emergency medical condition that will get worse from failure to obtain the treatment.
- To know in advance of obtaining treatment, if you are eligible for Medicare, whether the health care provider or health care facility accepts the Medicare assignment rate.
- 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 healthcare decisions now with these types of advance directives:
  - The "living will" states which medical treatments you would accept or refuse if you

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- 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 appeals about Health First Health Plans or the care provided.

**Additionally, you have the responsibility:**

- To understand your Health First Health Plans’ benefits and plan guidelines.
- To supply accurate and complete information, including unexpected changes in your health condition, (to the extent possible) that Health First Health Plans 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 and arriving promptly, and notifying your physician if you’re unable to keep a scheduled appointment in a timely fashion.
- To pay your cost-share or any other applicable fees according to your Summary of Benefits.
- To notify Health First Health Plans of any changes in your address, telephone number, or eligibility status.
- If you are enrolled in an HMO Plan, to use the designated Health First Health Plans’ participating primary care physicians, specialists, and medical facilities (except for emergency care).

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## **Notice of privacy practices**

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This notice describes how your Protected Health Information (PHI) may be used and disclosed by Health First Health Plans (HFHP), and how you can access this information. Please review this notice carefully, and contact HFHP’s Privacy Office at 321.434.5660 as needed.

### ***Our pledge regarding your protected health information***

At HFHP, our greatest concerns are your health and privacy. To properly administer your healthcare benefits, there will be times when we need to collect personal information, including medical information, about you so we can provide the superior service you expect. Rest assured that we are committed to using and disclosing this information responsibly, while respecting your privacy and keeping you informed about our practices. This notice will tell you about the ways we may use or disclose your

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protected health information, and also describes your rights.

### ***What is protected health information?***

For purposes of this notice, “protected health information” means any information that’s created or received by HFHP relating to your health, or the provision or payment for your health care.

We’re required by law to:

- make sure your protected health information is kept private;
- 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.

### ***How we may use and disclose health information about you***

The following categories describe the ways HFHP may use or disclose your protected health information. For each category, we’ll 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’re permitted to use or disclose your information will fall within one of these categories.

- **For payment:** We may use your protected health information to pay for the health care you receive. When necessary, we may also disclose your information to other insurance companies for benefit coordination.
- **For healthcare operations:** We may use and disclose your protected health information for healthcare operations, which include the following activities:
  - **Quality management:** 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:** Case management and care coordination.
  - **Credentialing:** Reviewing the competence or qualifications of healthcare professionals by evaluating their performance.
  - **Certification and licensing activities:**

Activities necessary to maintain our required licenses 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.
- **Medical review, legal services, and auditing functions:** Includes fraud and abuse detection and compliance programs.
- **Business planning and development:** Data analyses related to operating HFHP, including Formulary development and administration, development or improvement of payment and coverage policies.
- **Business management and general administrative activities:** Includes, but is not limited to:
  - Customer service
  - Resolution of internal appeals
- **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.

- **To individuals involved in your care or payment for your care:** We may release 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.
- **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 HFHP at the address at the end of this notice.
- **As required by law:** We’ll disclose your protected health information when required to do so by federal, state, or local law.
- **To avert a serious threat to health or**

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**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.

### ***Special situations***

- **Organ and tissue donation:** If you're an organ donor, we may release your protected health information 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.
- **Military and veterans:** If you're a member of the US armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation:** We may release your protected health information for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public health risks:** We may disclose your protected health information for public health activities. The purpose of these activities are generally to:
  - prevent or control disease, injury, or disability;
  - report births and deaths;
  - report child abuse or neglect;
  - report reactions to medications or problems with products;
  - notify people of recalls of products they may be using;
  - notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We'll only make this disclosure if you agree or when required or authorized by law.
- **Health oversight activities:** We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
- **Lawsuits and disputes:** If you're involved in a lawsuit or dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law enforcement:** We may disclose your protected health information if asked to do so by a law enforcement official in the following ways:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime, if under certain limited circumstances, we're unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the hospital; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, medical examiners, and funeral directors:** We may disclose your protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release your protected health information to funeral directors as necessary to carry out their duties.
- **National security and intelligence activities:** We may disclose your protected health information to authorized federal

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officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective services for the US president and others:** We may disclose your protected health information to authorized federal officials so they may provide protection to the US President, other authorized persons or foreign heads of state, or to conduct special investigations.
- **Inmates:** If you're an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official. This release would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

### ***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 copy your protected health information. This usually includes medical and billing records, but doesn't include psychotherapy notes. To request this information, you must submit your request in writing to HFHP at the address located at the end of this notice. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. The information will typically be provided within 30 days. We may deny your request in very limited circumstances. If you're denied access to your protected health information, you may request that the denial be reviewed. A licensed healthcare professional who didn't deny your original request will perform the review, and we'll comply with the decision of the new reviewer.
- **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 Health First Health Plans. To request an amendment, you must submit your request in writing to Health First Health Plans at the address located at the end of this notice. You must provide a reason that supports your request. We may deny your request for an amendment if it isn't in writing or doesn't include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- wasn't created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - isn't part of the information kept by or for HFHP;
  - isn't part of the information which you would be permitted to inspect and copy; or
  - is 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 weren't authorized by you.
  - To request this accounting, you must submit your request in writing to Health First Health Plans 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 may 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's involved in your care or the payment for your care. If we agree, we'll comply with your request unless the information is needed to provide emergency treatment to you. We're not required to agree to your request however. HFHP will not agree to restrict the

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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 HFHP 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 matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit your request in writing to HFHP at the address located at the end of this notice. We'll 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 HFHPs' Customer Service department at 321.434.5665 or 1.800.716.7737. You may also write to the address listed at the end of this notice, or obtain one through our website, [www.HealthFirstHealthPlans.org](http://www.HealthFirstHealthPlans.org). Even if you've agreed to receive this notice electronically, you're 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. Any revised notice will contain the effective date in a visible location.

### ***Concerns***

If you believe your privacy rights have been violated, you may file a concern with HFHP or with the Secretary of the US Department of Health and Human Services. To file a concern with Health First Health Plans, please write the address listed at the end of this notice, or call

HFHPs' Privacy Office at 321.434.5660. You won't be penalized for filing a concern.

### ***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. If you revoke your permission, we'll no longer use or disclose your protected health information for the reasons covered by your written permission. We're unable to take back any disclosures we have already made with your permission, and must retain our records of the services that we provided to you.

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

Health First Health Plans  
Attn: Member Advocate  
6450 US Highway 1  
Rockledge, FL 32955

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## **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

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illness. Any limits to the power of the surrogate in making decisions for you should be clearly expressed. 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, 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**

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As with any health plan, there are exclusions and limitations to be followed. If a member does not follow these notations when receiving services or supplies, the member risks having them not covered by this plan. In such a circumstance, the member would be responsible for the entire cost of the services rendered. Please refer to your Certificate of Coverage or Summary Plan Description for details regarding exclusions and limitations that may apply.

## **Glossary of terms**

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

**Allowable charge** — The amount charged or the amount Health First Health Plans 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.

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**Anniversary date** — The date established by Health First Health Plans and the group, as indicated in the Group Contract, when the Group Contract is renewed. Before that date each year, an open enrollment period will be scheduled during which time persons entitled to health benefits coverage may enroll in the health plan. Changes take effect on the anniversary date.

**Child** — The term includes the employee's natural born child, stepchild, foster child or legally adopted child of the employee upon placement in the employee'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 stated as a percentage of the allowable expense for covered services, coinsurance amounts are included in the Summary of Benefits.

**Contract** — The Group Master Contract between Health First Health Plans and the group/employer that includes the Certificate of Coverage, group application, and any riders, amendments, and attachments.

**Copayment** — A predetermined dollar amount listed in the Summary of Benefits that the member must pay for certain plan benefits.

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

**Eligible dependent** — An eligible dependent is defined as the employee's lawful spouse, and/or the employee's child until the end of the calendar year in which the child reaches age 26. The federal 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,

- b) is a state resident, or a full or part-time student;
- c) is not provided coverage under any other group or individual insurance policy or entitled to Federal or State benefits.
- d) is a member of an HMO or POS plan. ASO, TPA, self-funded or self-insured plans are not considered HMO plans. To inquire whether extended dependent eligibility coverage is applicable to your benefit plan, check with your employer, or your Plan Documents.

**Employee** — A person designated by the Contract between the group and Health First Health Plans who is eligible to enroll as a health plan member.

**Experimental/investigational** — Treatments, procedures, devices, drugs, or medicines determined to be experimental or investigational by Health First Health Plans. One or more of the following may apply:

- The device, drug, or medicine cannot be lawfully marketed without approval from the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows the treatment, procedure, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows the consensus of opinion, among experts acceptable to Health First Health Plans, regarding the treatment, procedure, device, drug, or medicine, indicates further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence means only published reports and articles in authoritative medical and scientific literature; the written protocol of another facility studying substantially the same treatment, procedure, device, drug, or medicine; or the written informed consent used by the treating facility or another facility studying substantially the same treatment,

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procedure, device, drug, or medicine. Health First Health Plans reserves the right to determine reliability of evidence.

**Group/employer** — The employer or legal entity that has entered into a Group Contract with Health First Health Plans under which the health plan will provide or arrange health services for eligible employees of the group who enroll.

**Group open enrollment period** — A time period of at least 30 days established by the group and Health First Health Plans during which eligible employees may enroll themselves and their eligible dependents under the health plan; may be scheduled periodically, but at least once a year.

**Medically necessary** — Services or supplies included under this health plan provided by a physician, hospital, or other provider to treat or diagnose a sickness or injury that, as determined by the health plan medical director, are:

- consistent with the symptom(s) or diagnosis and treatment of the sickness or injury; not primarily administered for the convenience of the member, physician, or other provider;
- the most appropriate standard of care in accordance with good medical practice that can be safely provided to the member;
- not of an experimental or educational nature;
- not provided primarily for medical or other research; and,
- not involving unnecessary or repeated tests.

*Note: The fact that a physician prescribes, orders, recommends, or approves a service or supply does not, of 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** — An employee 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 Health First Health Plans' service area; covered benefits for out-of-area

services are limited to urgent and emergency care unless arranged by a health plan physician and authorized by Health First Health 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 First Health Plans' 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 Health First Health Plans 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 or primary doctor** — A doctor who normally practices one of the following: family medicine, general internal medicine, or pediatrics.

**Prior authorization** — Certain services require approval from Health First Health Plans before the service is rendered to guarantee coverage. Your doctor must submit a request to Health First Health Plans 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, the member has the right to appeal the decision. Denials based on medical necessity are only rendered by licensed physicians.

**Plan documents** — Refers to either the Certificate of Coverage or Summary Plan

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Description 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 or work to be covered by this health plan.

**Self-employed individual** — An individual or sole proprietor who operates a business or trade that generates taxable income (as indicated on IRS Form 1040, schedule C or F), in one of the two previous tax years.

**Small group employer** — Any person, sole proprietor, self-employed individual, independent

contractor, firm, corporation, partnership, or association that:

- is actively engaged in business,
- has its principal place of business in this state,
- employed an average of 1–50 eligible employees during the preceding Calendar Year, and
- employs at least one employee on the first day of the plan year.

**Waiting period** — The employer-defined period of time following your hire date that must pass before benefits become effective.



*Inspiring healthy moments.*

6450 US Highway 1, Rockledge, FL 32955  
(321) 434-5665 • 1-800-716-7737  
TDD/TTY relay 1-800-955-8771  
Weekdays 8 am–5 pm, Saturdays 8 am–noon

[www.HealthFirstHealthPlans.org](http://www.HealthFirstHealthPlans.org)