

Introduction

This **Member Rights and More** brochure provides helpful information about your Florida Blue or Florida Blue HMO health plan. The more you know, the more you can maximize the benefits and services available to you from us.

Florida Blue's commercial and marketplace HMO and PPO plans have been accredited by the National Committee for Quality Assurance (NCQA®). NCQA is an independent, nonprofit organization located in Washington, D.C., that assesses the quality of managed care organizations. NCQA evaluates how well a health plan manages its network of physicians, hospitals and other providers in order to continually improve the health care coverage experience for its members.

Please take a few minutes now to read the following pages. Included is information about specific Florida Blue and Florida Blue HMO (hereafter just "Florida Blue") policies that are designed to protect you and your family and that are part of the standards used by NCQA when evaluating a health plan for accreditation. This information is available to you at any time upon your request.

What are my rights and responsibilities as a Florida Blue or Florida Blue HMO Member?

Florida Blue is committed to offering quality health care coverage, as well as maintaining the dignity and integrity of our members. Recognizing that service providers are independent contractors and not the agents of Florida Blue we have adopted the member rights and responsibilities below.

Rights

- To be provided with information about Florida Blue, our services, coverage and benefits, the contracting practitioners and providers delivering care, and members' rights and responsibilities.
- To receive medical care and treatment from contracting providers who have met our credentialing standards.
- To expect health care providers who contract with us to:
 - Discuss appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
 - Permit you to participate in the major decisions about your health care, consistent with legal, ethical and relevant patient-provider relationship requirements.
- To expect courteous service from Florida Blue, and considerate care from contracting providers with respect and concern for your dignity and privacy.
- To voice your complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in your member handbook or other procedures adopted by Florida Blue for such purposes.
- To inform contracting providers that you refuse treatment, and to expect to have such providers honor your decision if you choose to accept the responsibility and the consequences of such a decision.
- To have access to your records and to have confidentiality of your medical records

Health insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc. D/B/A Florida Blue HMO, an HMO affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

maintained in accordance with applicable law.

- To call or write to us anytime with helpful comments, questions and observations whether concerning something you like about our plan or something you feel is a problem area. You also may make recommendations regarding our members' rights and responsibilities policies. Please call the phone number or write to us at the address on your member ID card.

Responsibilities

- *(HMO members only)* To seek all non-emergency care through an assigned PCP or a contracting physician and to cooperate with all persons providing your care and treatment.
- To be respectful of the rights, property, comfort, environment and privacy of other individuals and not be disruptive.
- To take responsibility for understanding your health problems and participate in developing mutually agreed upon treatment goals, as best as possible, then following the plans and instructions for care that you have agreed upon with your Florida Blue provider.
- To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
- To be financially responsible for any co-payments and non-covered services, and to provide current information concerning your enrollment status to any Florida Blue affiliated provider.
- To follow established procedures for filing a grievance or appeal concerning medical or administrative decisions that you feel are in error.
- To request your medical records in accordance with Florida Blue's rules and procedures and applicable law.
- To follow the coverage access rules established by Florida Blue.

Your Confidentiality

Florida Blue respects your privacy and have policies and procedures designed to safeguard your personal information, in all forms—spoken, written and electronic. You already have been provided with a copy of our Notice of Privacy Practices. If you wish to view or obtain another copy, you may visit us at [FloridaBlue.com](https://www.floridablue.com) or call us at the number listed on your ID card.

Care without Discrimination

Members have a right to expect that health care providers who contract with Florida Blue's networks will not discriminate against members in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.

New Technology

The types of treatments, devices and drugs covered by your plan are extensive.

In light of the rapid changes in medical technology, it is important to continually look at new medical advances to determine which will be covered by your health care benefit package. Before covering new medical technology, we look at a number of factors. Procedures and

devices must be proven to be safe and effective by meeting certain criteria, among them:

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

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

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

The Value of a Primary Care Physician

Developing and continuing a relationship with a Primary Care Physician (PCP) or Family Physician allows the physician to become knowledgeable about you and your family's health history. A Family Physician or PCP can help you determine when you need to visit a specialist and also help you find one based on his or her knowledge of you and your specific health care needs. Care provided by Family Physicians usually results in lower out-of-pocket expenses for you.

Do I have to select a PCP?

It depends on the Plan you have. Please see below:

BlueCare and myBlue Plans - Yes. This plan requires that you select a participating Primary Care Physician (PCP) from your plan's network. If you seek care from a physician who is not your designated PCP, you will be responsible for the specialist copayment which is generally higher. Services provided from physicians who are not in your network are not covered, except in the case of a true emergency as defined in your policy. You may choose a new PCP at any time. You can call us or change your PCP online: log in at [FloridaBlue.com](https://www.floridablue.com) and find the "My Account" tab, then the "Primary Care Physician link. Your PCP change will be effective on the first day of the following calendar month if we receive your PCP change prior to the 15th of the month.

BlueChoice Plan - No. Under BlueChoice you are free to see any physician without a referral. However, you can minimize your costs by selecting physicians who are General Practitioners, Internists or Family Physicians, and who participate in our *BlueChoice* Preferred Patient Care (PPO) provider network.

BlueOptions or BlueSelect Plans - No. Under BlueOptions or BlueSelect, you are free to see any physician without a referral. However you can minimize your costs by selecting physicians who are General Practitioners, Internists or Family Physicians and who participate in *NetworkBlue* or the *BlueSelect* Network.

A Patient Centered Medical Home

Over 2,000 primary care physicians across Florida participate in our Florida Blue Patient

Centered Medical Home (PCMH) program. A PCMH or “medical home” is a medical office or clinic that emphasizes the physician-patient partnership in improving your health care. This holistic approach includes all of the factors that affect your health including behavioral and psychosocial aspects.

Participation in the program is entirely voluntary. By choosing a PCMH physician, you become part of the health care team, that includes you, your physicians and staff, and, if applicable, your family. Your PCMH physician will work with you to ensure your wants, need and preferences are respected. You can expect to spend more time during your visit with your health care team.

You will work with your physician or physician team member to achieve mutual health goals and expectations. Preventing problems before they occur is a major focus of the PCMH. You can expect to receive feedback and progress reports in language that is culturally diverse and easy to understand. Your PCMH office or another office within the group will be available to you before and/or after regular office hours. Your PCMH physician team will assist you in obtaining necessary referrals, and will ensure the feedback is integrated into your overall health care plan. Your prescription requests will be sent electronically directly to your pharmacy for your convenience.

Florida Blue PCMH physicians are listed in our online provider directory at [FloridaBlue.com](https://www.floridablue.com). Under “Find Doctor & More” choose “Patient-Centered Medical Home” under the Programs selection.

Appointments with your Physician

You don’t have to wait until you are sick to meet your new doctor or care team. It’s a good idea to make an appointment to meet with them and go over your medical history, including past and current medications.

- Share any special needs you may have such as a language interpreter.
- Write down your questions and bring them to your next office visit. If you don’t understand the answers, ask the doctor or nurse to explain in a different way.
- Work together with your PCMH team, PCP or Family Physician to set goals. They can be physical, emotional or social goals.
- Try to learn more about your health and how to improve it.

You can log in to [FloridaBlue.com](https://www.floridablue.com) to find a participating physician that matches your needs. Click on the [Find a Doctor](#) link and select your plan name under step 2 (your plan name is shown in the top right corner of your member ID card).

Our online provider directory gives you information about our physicians, including their specialties, phone numbers, addresses, languages spoken, and any age limits on patients. Or you can call member services at the number listed on your ID card (TTY users call 1-800-955-8770) to request a copy of the provider directory. It’s a good idea to check that the physician participates in your specific Plan when you call to make an appointment.

If you wish to check a physician’s education, licensing credentials or board certification, call the Department of Health at 1-850-488-0595, or link to their website through our online provider directory.

Should you wish to file a complaint against a provider or check the status of a disciplinary action against a provider, call the Agency for Health Care Administration Information Center at 1-888-419-3456

When Your Doctor's Office Is Closed—After-Hours Medical Care

You may need medical care when your Family Physician's or PCP's office is closed. In the event of a medical emergency, always go to the nearest hospital emergency room or call 911. If your medical condition is not an emergency, call your Family Physician or PCP. Your call will be answered by his or her answering service. The answering service will ask you questions that may include your doctor's name and a brief description of the reason for your call. The answering service then will call your doctor, who will call you back and give you instructions.

Specialist Care

BlueCare or myBlue Plan - There are times when your Primary Care Physician will recommend you seek care from a Specialist. A referral from your PCP is required to obtain services. Your PCP will handle all referrals and authorizations for care for you.

BlueChoice, BlueOptions or BlueSelect Plans – Even though you may select any specialist, your out-of-pocket costs will be lower if you choose a specialist that participates with your network.

Referrals to Hospitals

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

To maximize coverage please confirm with Florida Blue, your Family Physician, or your PCP that an approved authorization has been obtained. (For HMO members, care at any facility, other than an emergency room, received **prior** to authorization will not be covered.) If you have questions regarding the services authorized including the number of visits or days approved, the timeframe for these services, the facility, or the effective date of the authorization for these services, please contact member services, or ask your Family Physician or PCP to explain.

Services for Disease Management/ Complex Case Management

Florida Blue has Complex Case Management, Case Management, and Disease Management services to help members, their families and caregivers with serious and long-term health problems. By finding problems early, we have the opportunity to better help with cost-effective, quality health care. The services are voluntary and offered at no additional cost. When you have questions about health care services, treatments or need help figuring out the health care system, call 1-800-955-5692 and choose option #4; or you may go to our member website for additional information.

How do I access Mental Health or Behavioral Health Services?

Florida Blue's mental health service network is administered by New Directions. For specific information on these benefits, please refer to your member handbook and copayment schedule. New Directions follows NCQA standards regarding your ability to reach a provider easily and to get an appointment in a timely manner. New Directions evaluates quality improvement and utilization management activities and conducts member satisfaction surveys.

New Directions' Quality Improvement Committee continually addresses areas related to overall member satisfaction. Upon request, New Directions will make available to enrollees information about its Quality Improvement program, including a description of the program and a progress report on meeting its goals. To request a copy from New Directions, call 1-866-287-9569. For TTY, call the Florida Relay Service at 1-800-955-8770 or 711.

New Directions has a system of mental health professionals, including psychiatrists, psychologists and licensed therapists, providing both inpatient and outpatient care. To arrange an appointment, please call your Primary Care Physician, select a participating provider from our online provider directory, or call New Directions directly at 1-866-287-9569, 24 hours a day, seven days a week.

Emergency Services and Care – What if I have an Emergency?

Emergency services for the treatment of an emergency medical condition are covered at any emergency room (ER), in or out of your plan's network, without the need for a prior authorization from Florida Blue. You will be required to pay only the in-network copayment, coinsurance and/or deductible, if any, listed in your Schedule of Benefits or Benefit Summary.

If you receive a bill for emergency services afterwards, please send it to the Florida Blue address shown on your member ID card and include an explanation regarding the nature of the emergency. Florida Blue will process the claim according to your plan benefits.

HMO Members only:

- If you are admitted to the hospital as an inpatient at the time of the ER visit, your ER copay will be waived, but you will still be responsible for your hospital copayment, coinsurance and any deductible.
- If you go to the ER or are admitted, you must notify us as soon as possible. If a determination is made that an emergency medical condition did not exist, payment for the ER services provided before that determination will be your responsibility.
- Follow-up care must be provided by your PCP or a Specialist who participates in your plan. If you are told you need follow-up care after your ER visit, be sure to contact your PCP or participating Specialist first. Any follow-up care you receive that is provided by a doctor other than your PCP or a participating Specialist might not be covered.

Urgent Care Services - What are the alternatives to using the emergency room?

For non-critical but urgent care needs, you can reduce your out-of-pocket expenses and, in many cases, your wait time for care by using an urgent care center. All urgent care centers maintain extended weekday and weekend hours. Urgent care centers treat non-emergency conditions such as:

- Animal bites
- Cuts, scrapes and minor wounds
- Minor burns
- Minor eye irritations, infections or irritations
- Rash, poison ivy
- Sprains, strains, dislocations and minor fractures

Making Informed Decisions – How do I find information about health care providers?

In an effort to assist you in making informed decisions about your health care, Florida Blue provides a link on its website to the Florida Agency for Health Care Administration's Florida Department of Health website. This website provides physician and hospital information on a variety of medical outcomes. It includes data such as the number of surgeries performed in a particular hospital, whether a physician has medical insurance, and when a doctor graduated from school.

The Florida Department of Health website also provides a link to the Centers for Medicare & Medicaid Services Hospital Compare website, where you can compare the quality of care for hospitals in your region and the treatments they provide for various medical conditions.

Once you have linked to the specific provider's details on our online provider directory ([FloridaBlue.com](https://www.floridablue.com)/"Find a Doctor"), you can find the link for the Florida Department of Health website on the right side of the page.

For information on the quality of care provided at the hospitals in your region and the treatments they provide for various medical conditions you can link to the CMS Hospital Compare website [here](#).

How am I covered if I travel outside the State of Florida?

When traveling out of Florida, you're covered under the BlueCard® Program. You'll receive in-network benefits and will be protected from balance billing when receiving covered services from a BlueCard participating provider. To find a BlueCard participating provider, visit "Find a Doctor" at [FloridaBlue.com](https://www.floridablue.com), then click on either "Doctors & Hospitals Nationally" in the upper right corner, or call 1-800-810-BLUE. Check with member services regarding coverage out of the country, and then choose the "Doctors & Hospitals Worldwide" link.

Your financial responsibilities may vary depending upon the provider chosen under the BlueCard Program. For information on the BlueCard participation status of providers, call the BlueCard customer service at 1-800-810-BLUE.

Under the BlueCard Program, your financial responsibility may include:

1. Payment of any applicable deductible, copayment and/or coinsurance requirements;
2. Payment of expenses that are limited, excluded, or not covered;
3. Payment of any expenses in excess of any benefit maximum limitations; and
4. (HMO members only) Payment of any expenses for services where coverage authorization from Florida Blue was required and not obtained. *If you're an HMO member, call your PCP or plan to request prior authorization and/or pre-certification.*

Away From Home Care® (HMO members only)

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

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

What to do for guest membership: Call the member services number listed on your ID card to verify if your travel location is available for coverage. If available, an Away From Home Care enrollment application will be forwarded to you for completion. Once you arrive at your new travel destination, you will receive information from the host plan on how to access medical coverage.

Note: The above services may not be available to all Florida Blue group plans or members at this time.

What's covered by your plan?

Information about what is covered and what is not covered by your plan, including information about prescription drugs and specialty medication, such as in-office injectables, are described in your plan's member handbook, benefit summaries and medication guide. This information includes any prior authorizations or pharmacy guidelines that might apply. You can log on to your account at [FloridaBlue.com](https://www.floridablue.com) to review this information. If you still have questions, or wish to have hard copies of these materials sent to you, please contact member services at the number on your ID card. Additional information on medications is available by clicking on the [prescriptions](#) link.

How do I file a claim?

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

How do I contact Member Services?

Call us toll free at the number on your ID card, Monday through Thursday, 8 a.m. to 6 p.m., and Friday, 9 a.m. to 6 p.m.; or visit any of our [Florida Blue Centers](#). For the hearing- and speech-impaired who use telecommunication devices, call the Florida Relay Service at 1-800-955-8770.

Interpretation Services – What if I need language assistance?

We understand the diverse needs of our communities and our members. We employ many Spanish or Creole-speaking member service representatives and internal service associates to serve the large number of Floridians who speak Spanish or Creole. We also contract with an external interpretation agency to assist you, if necessary, in a variety of other languages.

Non-English-speaking members can obtain help at any Florida Blue office. There is no charge when we provide service in a language other than English. When a non-English-speaking member calls Florida Blue, we ask for the member's language preference. An internal service associate assists the member in that language whenever the service capability exists.

If you have any further questions concerning this matter or need additional assistance, feel free to contact a member service representative toll free, at the number on your ID card Monday

through Thursday, 8 a.m. to 6 p.m., and Friday, 9 a.m. to 6 p.m. For the hearing and/or speech impaired who use telecommunication devices, call Florida Relay at 1-800-955-8770 or dial 711.

Make Your Wishes Known – What if I’m incapacitated?

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

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

- A living will
- A health care surrogate designation (a person who has limited decision making powers)A durable power of attorney for health care (a person who becomes an attorney-in-fact and can make all decisions regarding care)
- A do-not-resuscitate order

You may obtain information regarding advance directives from the following sources:

- Your physician or health care provider
- Your local hospital or skilled nursing facility
- The Agency for Health Care Administration (AHCA) website: www.MyFlorida.com provides downloadable information, forms and a wallet card.

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

If you have complaints concerning noncompliance with the advance directive requirements, you may contact AHCA:

Agency for Health Care Administration
Subscriber Assistance Program
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456

How does Florida Blue manage and protect my health care experience?

Utilization Management

Utilization Management (UM) is part of our benefits management process and currently includes activities such as authorizations, concurrent review, discharge planning, retrospective review and the Case Management Program.

The authorization process is designed to review and record your inpatient hospital admissions and other services (e.g., outpatient services, office surgery, self-injectable medications, etc.) for medical appropriateness and coverage under your contract.

The concurrent review process is designed so nurses/concurrent review coordinators can evaluate and monitor your inpatient admission(s) throughout your service episode.

Discharge planning is designed to provide your timely and appropriate discharge from the acute-care hospital setting to your home or an appropriate alternate facility.

Retrospective review is an evaluation of the medical appropriateness of care/services that you already received.

Case Management is a voluntary program, which may be made available to you by Florida Blue if you have a catastrophic or chronic condition. For questions related to Utilization Management/ Case Management, please call member services at the number on your ID card.

Provider Financial Incentives Policy

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

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

Florida Blue is solely responsible for determining whether expenses incurred (or to be incurred) or medical care are (or would be) covered or paid under a contract or policy.

In fulfilling this responsibility, Florida Blue shall not be deemed to participate in or override the medical decisions of any Florida Blue member's practitioner or provider.

Florida Blue does not specifically reward practitioners or other individuals conducting utilization management and/or utilization review for issuing denials of coverage or benefits.

Financial incentives for utilization management and/or utilization review decision makers do not encourage decisions that result in underutilization. The intent is to minimize coverage and payment for unnecessary or inappropriate health care services, reduce waste in the application of medical resources, and minimize inefficiencies that may lead to the artificial inflation of health care costs.

Complaint, Grievance and Appeal Process

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

Oral complaints will be accepted either by telephone or in person. You may either call member services at the telephone number on the back of your membership card or go to your local Florida Blue office in person (the address is in your Member Handbook or available at FloridaBlue.com) to file your oral complaint. We are committed to resolving your complaint within a reasonable amount of time.

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

Florida Blue/Florida Blue HMO Grievance and Appeal Department

PO Box 44197
Jacksonville, Florida 32231-4197

Grievances or appeals relating to the denial of coverage by Florida Blue based on medical necessity must be filed within 365 calendar days from the date you receive the denial, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a shorter period of time from notice of the denial. Florida Blue will complete the review of your grievance/appeal and notify you of the decision within 30 calendar days from the receipt of your grievance for a pre-service denial, 60 calendar days for post-service denials, and within 72 hours of receipt of your request for denials Involving Urgent Care (and requests to extend concurrent care Services made within 24 hours prior to the termination of the Services). If additional information is necessary we will notify you within 24 hours and we must receive the requested additional information within 48 hours of our request. After we receive the additional information, we will have an additional 48 hours to make a final determination.

If you wish to give someone else permission to appeal on your behalf, we must receive a completed Appointment of Representative form signed by you indicating the name of the person who will represent you with respect to the appeal. An Appointment of Representative form is not required if your Physician is appealing a pre-service denial involving urgent care. An Appointment of Representative form is available at [FloridaBlue.com](https://www.floridablue.com) under the “Forms” link, or by calling the Customer Service number on the back of your ID Card.

Florida Blue contracts with External Review Organizations to provide external reviews for members who have received appeal denials. You or your authorized representative may file a request for an external review within four (4) months after the date of receipt of the adverse appeal decision. Most members of individual plans or group employee plans are eligible; however a few groups are exempt. If you are eligible for the external appeals review process you will receive information in your Member Health Statements and in your final appeal decision if appropriate.

You and your plan may have other voluntary alternative dispute-resolution options, such as mediation. Check your Member Handbook for information about what options may be available to you.

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

Preventive Care Guidelines – Which health care screenings are recommended for me?

Working with your Family Physician or PCP to stay well is as important as receiving treatment when you are sick. The latest United States Preventive Health Task force guidelines are available at [uspreventiveservicestaskforce.org](https://www.uspreventiveservicestaskforce.org). This information will help you and your doctor make sure you get the tests, immunizations (shots) and guidance you need to stay healthy at the different stages of your life.

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

Quality Care and Services

We're committed to providing you with access to quality care and services. To help us understand where improvements can be made, we periodically conduct customer satisfaction surveys. We also analyze a number of indicators that relate to effectiveness and accessibility of care, as well as use of services, using the Healthcare Effectiveness Data and Information Set (HEDIS®) established by the National Committee for Quality Assurance (NCQA). NCQA is an independent, nonprofit organization whose mission is to evaluate and report on the quality of the nation's managed care organizations.

The HEDIS scores identify health plans' areas of strengths and opportunities for improvement. By taking action to improve our scores, we are confident that we are also improving the care we provide you.

Some of the things we have done to improve care include providing educational materials to members and providers on various topics, and collaborating with physician groups to develop best practices for providing recommended care and screenings. We also expanded our Disease Management and Case Management programs for members with chronic conditions such as diabetes and congestive heart failure to help them better manage their health.

Our programs encourage cooperation and communication between us, the physician and you. We recommend working with your physician to get all appropriate preventive health screenings and care to help you gain and maintain optimal health.

The table below highlights some of the HEDIS 2016 Effectiveness of Care results, comparing the rates for our commercial HMO and PPO plans with the national averages.

2016 HEDIS® Effectiveness of Care Results*

Measure	Commercial HMO	National Average	Commercial PPO	National Average	Marketplace HMO	National Average	Marketplace PPO	National Average
Adult BMI Assessment	72.78	79.28	65.93	56.67	74.21	79.28	72.26	56.67
Breast Cancer Screening	70.97	73.64	69.07	69.63	76.46	73.64	73.69	69.63
Cervical Cancer Screening	75.91	73.15	73.48	71.72	64.48	73.15	59.85	71.72
Colorectal Cancer Screening	57.79	65.55	62.53	57.14	59.61	65.55	53.28	57.14
Comprehensive Diabetic Care								
Diabetic Retinal Exam (DRE)	30.17	56.31	41.61	47.09	35.04	56.31	34.31	47.09
A1C Testing	89.54	89.18	86.62	88.79	91.97	65.44	91.48	88.79
HbA1c >9% Poor Control**	32.60	34.05	40.88	44.31	61.31	53.97	57.42	46.63
Nephropathy	89.29	91.14	85.64	87.4	92.94	91.14	89.78	87.4
Controlling High Blood Pressure	53.33	65.44	46.34	53.45	61.31	65.44	51.34	53.45
Persistence of Beta Blocker	79.89	85.02	83.06	81.95	NA	NA	NA	NA

* Source: NCQA's Quality Compass® 2016

2015 Results reported in 2016, rates are percentages

** Inverted rate – lower % reflects better performance

Member Experience

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results report member satisfaction with services provided by their doctors and health plans during 2016. The

annual survey covers aspects such as the ability to get needed care, get care quickly, your doctor and the quality of care received, claims processing, and the ease of getting information from your health plan.

We also monitor members' verbal and written complaints to assess customer needs and expectations. Providing a snapshot of member concerns, this enables Florida Blue to address member issues one-on-one, as well as develop initiatives to improve service to all members.

The table below compares the responses of Florida Blue's members with the national average.

2016 Commercial CAHPS*	HMO	Quality Compass[®] Percentile	PPO	Quality Compass[®] Percentile
Getting Needed Care	87.0%	25th	92.9%	95th
Getting Care Quickly	86.0%	25th	90.4%	95th
Shared Decision Making	79.8%	10th	81.1%	25th
How Well Doctors Communicate	94.7%	25th	95.7%	50th
Overall Rating Measures				
Rating of Health Care	75.3%	10th	79.6%	75th
Rating of Personal Doctor	85.4%	50th	87.0%	75th
Rating of Specialist	78.8%	5th	88.8%	90th
Rating of Health Plan	65.0%	25th	77.4%	95th
Other Measures				
Health Promotion and Education	76.0%	50th	76.0%	50th
Coordination of Care	79.7%	25th	83.4%	50th
HEDIS[®] measures				
Flu (Ages 18-64)	36.9%	10th	43.7%	25th
Advising Smokers and Tobacco Users to Quit	81.3%	75th	78.6%	75th
Discussing Cessation Medications	56.3%	75th	44.2%	50th
Discussing Cessation Strategies	42.2%	25th	35.7%	25th
Aspirin Use	33.3%	10th	50.4%	95th
Discussing Aspirin Risks and Benefits	44.5%	NA	57.7%	NA
Color Key	Improved from 2016 or stayed same			
	Declined from 2016			
<i>NA = Comparison data not available from NCQA due to changes in question wording and response choices</i>				
<i>*Source: 2016 Adult Commercial CAHPS[®]. CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality.</i>				