

GENERAL INFORMATION

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 obtain services that are not covered by your plan, you will be financially responsible. Make sure to familiarize yourself with the benefits provisions, exclusions, and limitations of your plan before you seek services so you 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 BALANCE BILLING?

The amount the plan pays for covered services is based on the **allowed amount**. The allowed amount is the maximum amount the Health Plan will pay for a covered health care service. If a non-participating provider charges more than the allowed amount, you may receive a bill to pay the difference. This is called **balance billing**. Balance billing occurs when an out-of-network provider bills an enrollee for charges, other than co-payments, coinsurance, or any amounts that may remain on a deductible.

For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, the hospital may send you a bill to pay the \$500 difference. Contracted providers may not balance bill you for covered services.

Florida law prohibits out-of-network providers from balance billing you for:

- Covered emergency services; and
- Covered non-emergency services that are:
 - Provided in a facility that has a contract for the nonemergency services with the Health Plan, and
 - Provided when you do not have the ability and opportunity to choose a participating provider at the facility available to treat you.

For these covered services, the Health Plan is responsible for the reimbursement of costs to out-of-network providers minus your cost-share.

WHAT IS MY FINANCIAL RESPONSIBILITY?

- You are responsible for paying only your deductible, coinsurance, or copayments.
- Generally, you are not covered for services from out-of-network doctors. You are responsible for paying the full cost for unapproved services.

LIABILITY FOR OUT-OF-NETWORK SERVICES

- **Health Maintenance Organization (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.

Keep in mind that certain services require prior approval, regardless of the benefit plan you have.

EXCEPTIONS TO OUT-OF-NETWORK LIABILITY

- Emergency Services
- Urgent Care Services

QUESTIONS

If you have questions about your health benefit plan, there are several ways to contact us to obtain the assistance you need:

By telephone

If you have questions about your plan or need assistance in a language other than English, please contact Customer Service.

Toll-free: 1.844.522.5279

TDD/TTY: 1.800.955.8771

Our Customer Service hours are: **Monday through Friday** from 8 a.m. to 6 p.m.

By email

Send your questions or comments to: AHAP@HF.org

By fax

Send your fax to: 1.855.328.0062

By mail

Send correspondence to:

Customer Service
Health First Health Plans - AHAP
6450 U.S. Highway 1
Rockledge, FL 32955

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